Agenda – Health, Social Care and Sport Committee

Meeting Venue:

Committee Room 2 – Senedd

Meeting date: 27 September 2018

Meeting time: 09.15

For further information contact:

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Committee Clerk

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Informal pre-meeting (09.15 – 09.30)

1 Introductions, apologies, substitutions and declarations of interest

(09.30)

2 Dentistry in Wales: Evidence session with the British Dental Association

(09.30–10.15) (Pages 1 – 60)

Dr Caroline Seddon – British Dental Association Wales Director

Tom Bysouth – Chair of the Welsh General Dental Committee, British Dental Association

Christie Owen – Policy and Committee Officer, British Dental Association

Consultation Responses

Paper 1 – British Dental Association

3 Dentistry in Wales: Evidence session with the British Orthodontic Society

(10.15–11.00) (Pages 61 – 77)

Benjamin Lewis, Consultant Orthodontist, Wrexham Maelor and Glan Clwyd Hospitals, British Orthodontic Society

Paper 2 – British Orthodontic Society

Break (11.00-11.10)

4 Dentistry in Wales: Evidence session with the NHS Confederation and representatives of Local Health Boards

(11.10-11.55) (Pages 78 – 108)

Lindsay Davies Head of Primary Care, Primary and Community Services Delivery Unit, Abertawe Bro Morgannwg University

Karl Bishop, Consultant in Restorative Dentistry, Abertawe Bro Morgannwg University Health Board

Craige Wilson, Assistant Director of Primary Care, Children's and Community Services, Cwm Taf University Health Board

Vicki Jones, Clinical Director of the Community Dental Services and Consultant in Special Care Dentistry, Aneurin Bevan University Health Board

Paper 3 – NHS Confederation

Paper 4 – Abertawe Bro Morgannwg University Health Board

Paper 5 – Cwm Taf University Health Board

Paper 6 – Aneurin Bevan University Health Board

Break (11.55-12.35)

5 Dentistry in Wales: Evidence session with Wales Deanery and the School of Dentistry, Cardiff University

(12.35-13.20) (Pages 109 – 117)

Professor David Thomas, Director Postgraduate Dental Education, Wales Deanery

Dr Richard Herbert, Associate Dean, Wales Deanery

Professor Alastair Sloan, Head of School, School of Dentistry, Cardiff University

Paper 7 – Wales Deanery

Paper 8 – School of Dentistry, Cardiff University

6 Dentistry in Wales: Evidence session with the Chief Dental Officer

(13.20-14.20) (Pages 118 - 125)

Dr Colette Bridgman, Chief Dental Officer

Frances Duffy - Director, Primary Care and Innovation, Welsh Government

Andrew Powell-Chandler - Head of Dental Policy, Welsh Government

Paper 9 – Welsh Government

7 Paper(s) to note

(14.25)

7.1 Letter from the Royal College of Nursing to the Chair - Brexit Symposium

(Pages 126 - 147)

8 Motion under Standing Order 17.42 to resolve to exclude the public from the meeting for the following business:

(14.25)

9 Dentistry in Wales: Consideration of evidence

(14.25-14.35)

Agenda Item 2

Document is Restricted

The Welsh Assembly's Health, Social Care and Sport Committee's Inquiry into Dentistry in Wales 2018

Response by the BDA Wales

"More than Words"

The BDA

We are the voice of dentists and dental students in the UK. We bring dentists together, support our members through advice and education, and represent their interests. As the trade union and professional body, we represent all fields of dentistry including general practice, community dental services, the armed forces, hospitals, academia, public health and research.

Contents

Acknowledgments

We are particularly grateful to the BDA members for taking part in the August 2018 survey - thank you.

Thanks go to the BDA Staff:

- Ms Sarah Carlin, for conducting the Membership survey
- Ms Christie Owen, for conducting the research that supplied much of the data in the report, including the FOI investigations and the Telephone Survey, and their analyses

Thanks go to all the members of the Wales Craft Committees, and in particular the Chairs and Vice Chairs for their contributions and leadership:

- Dr Katrina Clarke, Chair, Welsh Council
- Mr Roger Pratley, Vice Chair Welsh Council
- Mr Tom Bysouth, Chair, Welsh General Dental Practitioners Committee
- Ms Lauren Harrhy, Vice Chair, Welsh General Dental Practitioners Committee
- Dr David Johnson, Chair, Welsh Committee for Community Dentists
- Dr Kenneth Hughes, Vice Chair, Welsh Committee for Community Dentists

The Welsh Assembly's Health, Social Care and Sport Committee's Inquiry into Dentistry in Wales 2018

Response by the BDA Wales
"More than Words"

Introduction

1 The BDA Wales greatly welcomes this inquiry into dentistry and the opportunity to present our views, which have been carefully crafted by gathering and analyzing various data, many of which are not normally in the public domain, and by consulting widely with our craft committees and our membership who are daily facing the challenges of delivering dentistry in Wales. We undertook a survey of our members in Wales especially for this inquiry and the results are in *Appendix 1*.
We have representatives from the Local Dental Committees (LDCs) on our committees and expect the LDCs to make their own submissions. We look forward to making our oral presentation to the committee on 27 September 2018. The focus of the inquiry, and therefore our response, is general dentistry, orthodontic dentistry and certain aspects of community dentistry. However, we acknowledge the important contributions to patient care by all the dental crafts.

2 The BDA Wales wishes to highlight the very important part that good oral health plays in the overall health of the person. When oral health suffers it can have detrimental effects on a person's mental health as well as physical health. We have long-held the view that "the mouth needs to be put back in the body". The Royal College of Paediatrics and Child Health's report, *State of Child Health 2017*[1] asserts that **good oral health is essential for children's overall health and well-being**. Furthermore, when considering services for health and social care there needs to be "proper joined-up thinking". This philosophy is captured in the tenets of *Healthier Wales 2018*[2], which is warmly welcomed. Such tenets, however, need to be translated into action and system change.

3 We also wish to emphasize that the various challenges surrounding general dental practice - including the 2006 General Dental Services (GDS) contract & Units of Dental Activity (UDAs), clawback, contract reduction, poor recruitment/retention and practice closures - are tightly inter-linked and that the combination is leading to a substantial problem with patient access to NHS dentistry. We trust this response helps to explain these complex inter-dependencies. In the current term of the Assembly, BDA Wales has strenuously engaged with stakeholders including Assembly Members to convey the evidence that NHS dentistry in Wales is at a tipping point.

4 A major challenge in presenting this report has been the difficulty in accessing relevant data - much of them were derived by Freedom of Information (FOI) requests. There are other data that are simply not available. Assembly members may think that all is well with dentistry in Wales. However, "*absence of evidence is not evidence of absence*". We believe the Government and Health Boards have a crucial role to play in ensuring this evidence is comprehensively gathered, fully analysed and made publically available.

Dentistry services - NHS and private - are highly regulated and quality assured, as are dental professionals. The Government website is out of date so a summary of these regulations from 2006 onwards (including those for patient charges) is given in *Appendix 2.*
A glossary is provided in *Appendix 9.*

Dental Contract Reform

5 The 2006 England and Wales General Dental Service Contract and Welsh pilots for contract reform are discussed in detail in *Appendix 3.*

6 The 2006 GDS contract was flawed from its inception and has caused untold havoc ever since. Many practice owners in the intervening decade have struggled to make it work and then given up, either by handing back their NHS contract and only practising privately, or by selling their practice - often to a corporate (see pg 18 and *Appendix 9*) - and then working (often reduced hours) as an associate in that practice. The other option favoured by increasing numbers of practice owners is to simply retire early, as the reduction in the lifetime pension allowance might tip the balance. (See the *training and recruitment* section.)

7 Because of the nature of the 2006 dental contract, dentists can be reluctant to take on patients with higher needs as they are effectively penalised for doing so. This is because the NHS funding system operates blind to the extra costs of these patients and furthermore dentists need to achieve 95% of their targeted units of dental activity (UDAs) to avoid clawback of funding from the local Health Board. As a result, there is a systemic disincentive for dentists to take on the patients who need their services the most. We refer to this as the *inverse care law*. (See *Appendix 3* for further explanation.)

8 To test alternative systems of payment to dentists and new approaches to the delivery of NHS dental services in Wales, The Welsh Dental Pilot programme[3] was developed. It ran from 2011 to 2015 and focused on widening access; improving quality; and incentivising prevention. Two of the eight pilots moved on to a trial of a more advanced 'prototype' of the new contract in 2016 based on 85% capitation/15% quality. However, following the announced contract reform[4] by the new CDO in 2017, the 'prototype' contract was not rolled out, with the two 'prototype practices' remaining as such and not returning to UDAs. Instead, in September 2017 a new pilot scheme began, now with 21 practices taking part. This pilot scheme works with a modest 10% of UDAs given over to oral health needs assessment data collection.

9 The BDA Wales supports any reform of the contract that allows for prevention and the oral health needs assessment element. We are pleased to be part of the contract reform project board and a source of expertise and guidance. However, we have yet to be convinced that, without root and branch reform of the GDS contract, these goals of prevention can be achieved. We support a direction of travel that results in UDAs and clawback eventually being outmoded.

Clawback and Handback in General Dentistry

10 The BDA Wales has conducted several FOI Requests looking into the amount of monies clawed or handed back by each of the Health Boards in Wales and also the contract reductions resulting from clawback. In May 2017 we published our findings in BDJ in Practice[5] and have added to the data since then. We have submitted our findings to the BDJ (August 2018)[6.] Clawback is explained thoroughly in *Appendix 3.*

11 In three years, from 2014/15 to 2016/17, a total of **£16,322,445** was clawed or handed back to the Health Boards in Wales. See table 3 in *Appendix 3* for a breakdown. Table 4 in *Appendix 3* shows the number of practices affected by clawback in the last three years. It is evident that many practices, (indeed in some health boards the majority of practices), have experienced clawback in this period. In Wales overall, 31% of practices experienced clawback in 2017 which compares with 41% in 2016. These findings chime with the sample of 20 practices in the BDA telephone survey in 2017 which

showed that 60% of practices experienced clawback. In those telephone conversations it was apparent that practice managers and practice owners felt a strong sense of failure, and were hesitant to discuss their own clawback circumstances until it was explained that clawback is actually wide-spread, affecting around one third of practices.

12 The fact that fewer practices had clawback in the last year but the total clawback remained the same means that those practices affected will have suffered higher rates of clawback. This is however, not the full picture.

13 After two years of clawback such practices are then at risk of permanent contract reductions.

14 The BDA discovered that all Health Boards were applying permanent contract reductions to a greater or lesser extent. Table 5 in *Appendix 3* shows contract reduction over the three-year period between 2014/2015 to 2016/2017. Our research shows that over **a quarter** (26.5%) of all NHS practices in Wales have experienced **contract reduction** in the last 3 years. This amounts to approximately **£4,323,078**. Hywel Dda Health Board alone effected more than half of this contract reduction.

> The sums of clawback, handback and contract reductions combined add up to
> **£20,645,987**
> of the dental budget removed in just three years from general dentistry
> away from direct patient care.
>
> *(The breakdown is shown in Appendix 3.)*

15 Health Boards have not yet disclosed what happens to the monies clawed back, handed back or reduced from GDS contracts: Replies to our FOI requests are overdue from six Health Boards. We know unofficially that some use it to "balance the books" i.e. the money has been used for areas other than NHS dentistry. One Health Board is proactive in seeking to reinvest a portion of the clawback into practices' infrastructure.

16 It is vital that Health Boards are transparent in their accounting practices, and that they are held accountable by the Welsh Government. Given the amounts of money clawed back every year, there are ample yet unrealised opportunities for greater investment in existing oral health programmes, including Designed to Smile. (*See section on oral health programmes.)*

17 It seems perverse that the Welsh Government has put up patient charges twice in the last two years, obtaining an estimated extra £2.6 million in the process, and yet in that **two-year period** alone there has been a total **clawback of circa £13 million**. It is well-understood that patient charges were originally introduced to cause rationing of dental care. Remarkably, there has been *a sharp increase in the proportion of patients paying charges relative to the increase in patient numbers in Wales in the last six years*, according to the Government's own data, as shown in *Appendix 4.* This is inexplicable. Whilst we acknowledge that charges are lower than in England, we challenge this creeping escalation and the impact it will have on lower income families who are not exempt.

Training, Recruitment and Retention

18 Government data show that NHS general dentistry in Wales is at a time of significant change. The number of providers who are also NHS performers (providing-performers) across Wales has more than halved in the 6 years from 2010 to 2016, from 418 to 201. The fall in providing-performers is unexplained because no systematic Wales-wide survey has looked at this issue. However, if numbers

continue to decline at current rates, there will be near zero providing-performers left in NHS dentistry in five years' time. NHS Digital this month[7] said: "*Nearly two-thirds of Principal dentists and over half of all Associate dentists across the UK often think of leaving dentistry."*

19 Many practices in rural Wales are struggling to see all their patients, let alone new patients, as they are having trouble recruiting and retaining associates. The BDA Wales telephone survey in 2017 covered all the Health Boards and showed that of those 20 practices surveyed, 50% of them believed their problems with recruitment and retention had led to clawback, thus affecting patient access.

20 Problems with recruitment and retention of associates, together with a vast reduction in providing-performers, has inevitably resulted in NHS dental contracts being reduced or returned altogether and large numbers of patients being left without access to NHS dental care. Such matters have been made clear to Welsh Government including in the last DDRB evidence. Yet in last year's evidence the Government held down the number of training places for dentists, despite continuing and predicted population growth as shown by the public health observatory (2016)[8]. They instead proposed increased numbers of training places for Dental Care Professionals (DCPs). This however masks the fundamental issue that we need more 'home-grown' dentists in Wales. (Please refer to *Appendix 5* for a fuller picture.)

21 The depressed environment of NHS dental practice has contributed to some of the lowest scores for motivation and morale across dentists in Great Britain. This is discouraging young dentists from undertaking a career within NHS dentistry and compelling experienced dentists to leave the NHS or the entire profession. NHS Digital this month[7] said: "*The more time dentists spend on NHS/Health Service work, the lower their levels of motivation."* The recent announcement from the DDRB of a 2% pay uplift (yet to be confirmed in Wales - but in England will not be backdated so is in effect 1% for the 12-month period to March 2019) again represents another pay cut in real terms and will only exacerbate the present situation.

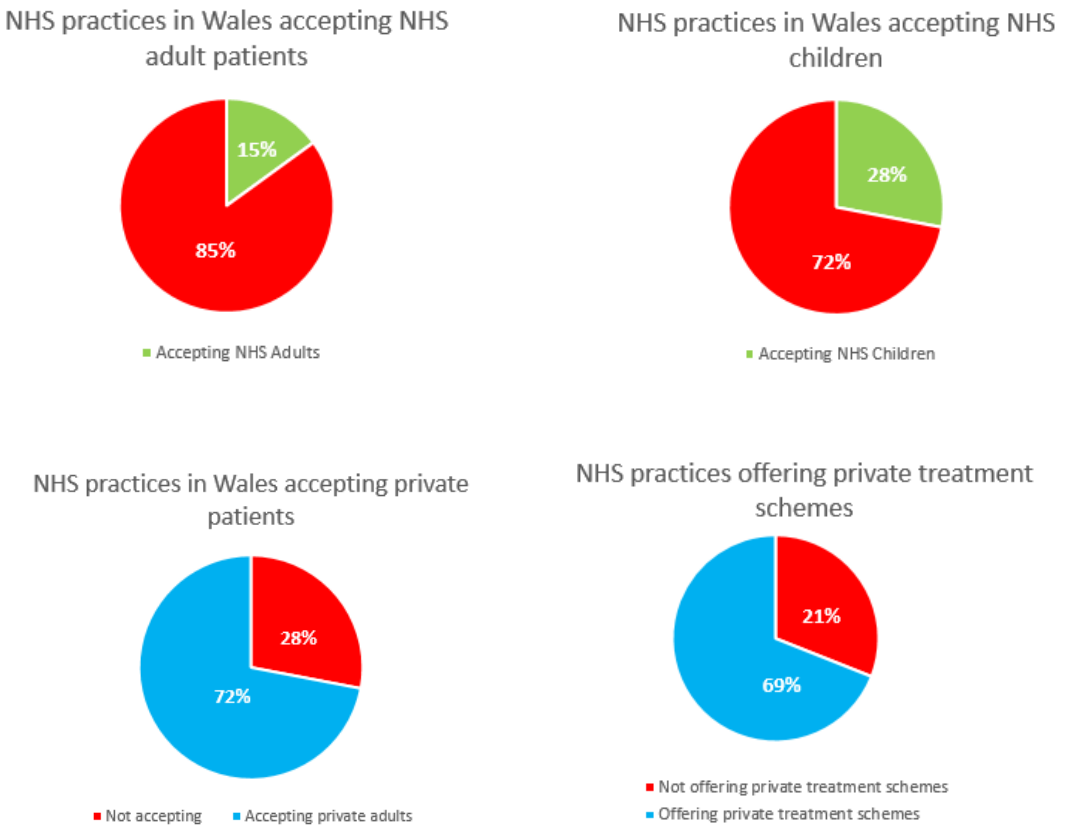
Access to NHS general dentistry

22 The BDA Wales wishes to draw particular attention to the impacts that the GDS contract, UDAs, clawback, under-recruitment of dentists, dental practice closures and under-spend of the GDS budget are having on access to dentistry in Wales. In 2017 BDA Wales undertook research into levels of patient access, and we submitted our findings in a paper to the British Dental Journal (BDJ) in August 2018[6]. This research shows that access for new NHS patients to primary care dentistry has plummeted in the last few years to an all-time low. Figure 1 below summarizes key findings.

23 In 2017 we found that only **15%** on average of all NHS practices were accepting **new adult NHS patients** and only **28%** of all practices were accepting **new child NHS patients**. In many cases this was with a waiting list. Therefore, based on current levels, nearly three quarters of children being born in Wales today will struggle to access an NHS dentist. This is down to the contract cap put on each dental practice by the Health Boards, which in turn are constrained by the Government's dental budget allocations. The Royal College of Paediatrics and Child Health's report *State of Child Health 2017*[1] lists ***access to timely primary dental care*** as a key health objective. The reality is that this objective is currently not possible. If children cannot easily access NHS dentistry, then good oral health cannot be achieved and maintained.

24 This problem of access is not peculiar to Wales. In January 2018, Healthwatch England, the patient watchdog, published six priorities for NHS England including *Tackling access issues in NHS dentistry*[9]. Healthwatch England and their 52 branches have published extensively about problems with access to dentistry in the last few years. Wales needs a strong voice for patients. The Community Health Councils are being wound down and in any case have lacked patient experience of dentistry data.

Figure 1 showing percentages of dental practices accepting new patients (including via waiting lists).



25 The newly reconfigured National Survey for Wales[10,11] asks 11,000 people every year about their health and lifestyle and access to services. We are disappointed that the only question asked currently is how many natural teeth the person has. No questions are asked about access to dentistry.

26 The population of Wales is projected[8] to increase by almost 9%, from around 3.1 million in 2011 to over 3.3 million in 2036. The 65-to-84 and 85+ age groups are projected to have the largest increase by 2036, when an estimated 1 in 4 people in Wales will be aged 65 and over. This changing demography will require additional resources to meet the increased need for restoration. Yet the latest Government figures[12] show an actual fall of 0.4% in courses of treatment in the last year 2016-2017.

Orthodontic Services

27 The number of orthodontic performers in Wales has reduced by 38% from 133 to 82 between 2008-09 and 2015-16. There is evidence of significant reductions in performers in Betsi Cadwaladr and Hywel Dda. The budget for Personal Dental Services (PDS) has reduced in the last three years. (See *Appendix 6*.) Not surprisingly this has had a severe effect on waiting times. Dentists working in various Health Boards in Wales have been known to refer patients more than 3 years in advance of their needing treatment as this is the only way for dentists to ensure that patients are treated at the time they would need orthodontic services. In 2014, an FOI request[13] discovered that Cardiff and Vale had the second largest waiting list in Wales. (See *Appendix 6* for further information.)

28 In 2017, there was a target to reduce waiting times to 6 months for Hywel Dda Health Board. There was no plan included in this target. Now, Hywel Dda has a 5-year waiting list. This year, the commissioning of UOAs (Unit of Orthodontic Activity) has a reduced unit value.

29 We appreciate the work being done by the Welsh Government on the new electronic referrals system which should markedly improve data quality by ensuring robust systems for **data recording** and transparent reporting on all aspects of orthodontic provision in all provider settings.

The effectiveness of oral health improvement programmes

30 Tooth decay is an entirely preventable disease and using schemes to educate children on oral health can have a significant positive impact on oral health. Wales has had some success in recent years with Oral Health improvement programmes, but there is much more to be done.

31 The Well Being in Wales (2017)[14] report claims that oral health in children is improving. However, this presents a partial picture and is based on comparisons with old data from 2007/8. We would suggest that the Well-being of Future Generations (Wales) Act 2015 is forward looking legislation and that a true picture of oral health improvement is more nuanced, including the adverse effects of deprivation. (See *Appendix 8* for further information)

32 Of those BDA members who took part in our survey, 90% would like to see new oral health programmes for older primary school children. There is plenty of evidence showing that many older children and young teenagers in Wales still have poor oral health. In 2016-2017 on average 29.6% (37.5% most deprived quartile) of 12-year old children had dental decay[15]. In 2013 66% of 15 year-old children had obvious dental decay experience[16]. NICE Guidance[17] recommends raising awareness of the importance of oral health, as part of a 'whole-school' approach in all primary schools and secondary schools too. Considering only a quarter of GDS practices across Wales are accepting new child patients then the Government needs to substantially invest clawback money in preventative schemes aimed at all children and also their parents.

Recommendations

See *Appendix 1* for the full list of responses from BDA members

GDS Contract

1) The Welsh Government must make the pledge that everyone should be able to access good quality NHS dental services - and then provide the resources to fulfil it, including establishing minimum UDA values and an uplift of UDA values in areas of deprivation.

2) The contract must move away from UDAs and towards meaningful performance measures and capitation for effective preventative dentistry and the provision of care needed for patients with poor oral health.

Clawback

3) It is vital that Health Boards are transparent in their accounting practices, and that they are held accountable by the Welsh Government for any underspend of the GDS budget.

4) Welsh Government should enforce Health Board KPIs for delivery of the GDS contract. Health Boards should account for how the clawback will be fully reinvested, including in oral health programmes for children of all ages. No clawback money should be reabsorbed into the general budget.

Patient experience

5) Systematic research should be conducted showing the experience of patients and would-be patients, including access to dentistry and the impacts of this on the population as a whole.

6) The National Survey for Wales must include patient experience of dentistry and access to dental services. The latter could be addressed by a simple question – W*hen did you last visit a dentist?*

Workforce

7) The Government should take fully into account the changing demography of Wales and the future requirements of the population in planning the dental workforce of the future.

8) Welsh Government must conduct an evidence-based review of the dentist workforce ensuring the requirements for the future for all dentistry crafts, including community dentists, will be fully met. The Government must not rely on skills-mix as the alternative to training more dentists in Wales.

9) The Welsh Government must ensure dentists' pay does not continue to be eroded as it has been in the last decade, and from now on should ensure annual uplift keeps pace with real inflation.

Orthodontics

10) As advised in 2016, the Welsh Government and the Orthodontic Strategic Advisory Forum should lay out a clear **strategy** for orthodontics in Wales for the next 5 years.

11) Health Boards must produce clear plans on how they intend to reduce waiting lists for orthodontic services, as well as updates on the effectiveness by showing outcomes data.

Oral Health Programmes

12) The Government should fund the D2S programme sufficiently that the 5 and 6 year-old children can receive the same benefits of inclusion as they did previously, including fluoride varnish.

13) The Government should ensure that age-appropriate oral health programmes for up to 12 year olds are delivered through schools in all Health Boards in order to address high prevalence of decay in that age group. There are more than enough funds from clawback to provide this.

14) The Government should do much more in promoting oral health messages and restricting access to sugar and sugary drinks in schools, hospitals and other public-funded organisations.

Data Analysis and Reporting

15) Official data about dentistry and oral health need normalisation against population numbers to allow for proper intra- and inter-Health Board comparisons on performance.

16) Many elements of data collection and reporting across the Health Boards need a major overhaul. Comprehensive data on dentistry budgets need to be systematically collected and transparently and routinely reported by these procuring authorities for public access.

Conclusion

This inquiry must produce **more than words** to make a real difference to dentistry in Wales.

Appendix 1: Summary of results from BDA Wales membership survey

The BDA conducted a survey of its members in Wales in August 2018 to help inform our response to the inquiry. Those who responded were GDPs (68%), community dentists (19%) and 12% working in hospital or other dentistry roles. We are very grateful to the 79 dentists who took part.

We received responses from across all the Health Boards. The largest response came from dentists in the Betsi Cadwaladr University Health Board (24.36% of respondents), closely followed by Cardiff & Vale University Health Board (20.51%).

Table 1. Recommendations from the BDA Wales membership to the Welsh Government:

Recommendation	Strongly Agree or Agree	Disagree or Strongly Disagree
Invest more in dentistry in Wales, to improve access and address oral health inequalities	96%	1%
Freeze patient charges, and provide additional investment from general taxation	38%	30%
Provide a prevention-based NHS dental contract that makes a decisive break from targets	87%	1%
Limit the marketing and promotion of sugary foods and drinks to young children	94%	1%
Ensure Clawback from NHS dental contracts should be reinvested back into NHS dentistry	97%	0%
Do more to encourage younger dentists to work in Wales	86%	0%
Raise awareness of the fact that NHS dentistry is free for under-18s, and exempted groups	78%	3%
Do more to inform parents of young children about the dangers of sugary food and drinks for good oral health	96%	0%
Extend the Designed to Smile programme to children aged 5-12, to address the concerning levels of tooth decay in these age groups	90%	5%

There were five response options:
strongly agree, agree, neither agree nor disagree, disagree, strongly disagree

Table 2. Members' reports on dental caries and oral health status of young children and oral health promotion activities

Question	Yes	No	?
Q3 Practices who saw more than 40% of younger child patients with visible signs of tooth decay?	**36%**	**61%**	**3%**
Q5 Do you do any unfunded oral health promotion from your practice or work place, e.g, putting up posters in your practice highlighting the dangers of sugar, or whilst carrying out school visits, etc.	**86%**	**11%**	**3%**
Q4: What other preventable oral health problems are you seeing in young child patients?	*Tooth loss, erosion (including acid erosion caused by fizzy drinks, or perceived 'healthy' fruit juice drinks), gingivitis and abscesses, poor oral hygiene and poor diets, dummy usage up to school age*		

Appendix 2: Regulations governing NHS and private dentistry in Wales

The government web page is out of date so the up-to-date list is provided here:

2018
The National Health Service (Dental Charges) (Wales) (Amendment) Regulations 2018

2017

a) Private Dentistry (Wales) Regulations 2017

b) The National Health Service (Dental Charges) (Wales) (Amendment) Regulations 2017

2015
The National Health Service (Dental Charges) (Wales) (Amendment) Regulations 2015

2014
The National Health Service (General Dental Services Contracts and Personal Dental Services Agreements) (Wales) (Amendment) Regulations 2014

2013
The National Health Service (Dental Charges) (Wales) (Amendment) Regulations 2013

2012
The National Health Service (Primary Dental Services) (Amendments related to Units of Dental Activity) (Wales) Regulations 2012

2010
The Local Health Boards (Consultation with Local Dental Committees) (Wales) Regulations 2010

2006

a) The National Health Service (General Dental Services Contracts and Personal Dental Services Agreements) (Amendment) (Wales) Regulations 2006

b) The National Health Service (Performers Lists) (Wales) (Amendment) Regulations 2006

c) The Functions of Local Health Boards and the NHS Business Services Authority (Primary Dental Services) (Wales) Regulations 2006

d) The National Health Service (Dental Charges) (Wales) Regulations 2006

e) The National Health Service (General Dental Services Contracts) (Wales) Regulations 2006

f) The National Health Service (Personal Dental Services Agreements) (Wales) Regulations 2006

g) The Functions of Local Health Boards (Dental Public Health) (Wales) Regulations 2006

h) The Health and Social Care (Community Health and Standards) Act 2003 Commencement (Wales) (No. 4) Order 2006

i) The General Dental Council (Professions Complementary to Dentistry) (Dental Hygienists and Dental Therapists) Regulations Order of Council 2006

Appendix 3: The 2006 NHS GDS contract, UDAs, clawback, contract reform and members' views

A) The NHS Dental Contract explained

1. The NHS General Dental Services Contract was developed by the Department of Health and came into force on the 1st April 2006 in England and Wales. (Scotland and Northern Ireland operate different types of GDS contracts.)

2. Dental practices are constructed to run as independent businesses; having to cover all running costs, capital expenditure and overheads as well as salaries. Practices contract with the commissioner, (in Wales this is the Health Board), for an NHS dental contract. The practice performance is scrutinised and closely managed against targets. (See section on clawback.)

3. The contract's system consists of three bands that determine how much the patient is charged for their treatment and how much the dental practice is remunerated by the Health Board.

    i. Band 1 includes diagnosis, treatment planning and maintenance, for example a clinical examination, assessment and report and an x-ray.

    ii. Band 2 includes all necessary treatment covered by band 1 plus additional treatment such as fillings, root canal therapy and extractions.

    iii. Band 3 includes all necessary treatment covered by band 1 and band 2 plus more complex procedures and provision of appliances, for example, bridges, crown and dentures.

4. The patient charge costs in Wales have been increased by Welsh Government twice in the last two years: Band 1 costs £14; Band 2 costs £44; Band 3 costs £195. Patients on benefits are exempt from paying dental charges and all patients are exempt from paying drug prescriptions. http://www.healthcosts.wales.nhs.uk/proof-of-entitlement

5. The 2006 contract changed the way that dentists are contracted, through the introduction of UDAs (Unit of Dental Activity). Dental practices are evaluated on the UDAs they achieve against the contracted allowance of UDAs allocated by the health Boards. These UDAs are linked to the three-band system.

    i. Band 1 is classed as 1 UDA, Band 2 is 3 UDAs and Band 3 is 12 UDAs.

    ii. UDA values vary considerably between practices and between Health Boards. Average Health Board values vary between £23.38 and £29.96, but there is considerable variation and many UDA values are too low to be workable.

6. The contract does not take into account the extent of the work required within a band. For example, in Band 2 a dentist will receive 3 UDAs whether they perform one filling on a patient, or three fillings and an extraction on a patient. This is considered to be one single course of treatment – regardless of the dentist's time taken and the cost of materials required. (Dentists' activities are highly scrutinised by NHS Business Services and HIW and

outliers are individually inspected and fined for any separation of activities within a course of treatment.)

7. It is worth considering that the dental budget spent in the last three years (£133,005,780 per annum) equates to £42.72 per capita per annum.That compares with the whole Health budget of £2,300 per capita per annum, or 1.9%. Given that 54% of the population were treated in 2017 (1,710,254) that equates to approx £78 per patient, or roughly 3 UDAs.

8. The real costs of treating high needs patients are therefore not accounted for within the contract and can often represent a loss to the dental practice business. Where there may be high needs patients not currently registered with a practice their potential treatment costs would not be covered by the UDA value, so there is no incentive for practices to alter their patient lists to include them.

9. The contract therefore acts as a strong disincentive for dentists to treat high needs patients owing to the broken business model. It is a misnomer to talk about units of dental activity when they are clearly expected to be infinitely elastic and not a unit in any normal business sense. The UDAs do not work for high needs patients and are consequently not fit for purpose.

10. Not only do dentists not receive remuneration commensurate with the work done for high needs patients, but in areas where good oral health predominates dentists are not remunerated should they attempt to treat more patients than their contract allows because of the cap imposed by the contract. This creates a barrier to improving patient access generally.

11. Over 90% of dentists say the 2006 contract has limited their capacity to treat patients with high needs.

B) What is Clawback?

1. If a dental practice fails to achieve 95% of their UDA target they will face clawback.

2. These Health Boards have a variety of different ways of handling clawback. Some clawback everything owing, others allow the dentist to carry 5% over to next year and only claw back the excess, some deal with dentists on an individual basis.

3. Setting targets can be helpful to productivity in many circumstances, but it does not work with UDAs. A dentist facing clawback could have worked longer hours and helped more patients with more challenging ailments than a dentist who has completed their UDA targets. This is in part due to the banded systems relation to UDAs. (See previous section.)

C) What is Handback?

1. If a dentist is struggling to achieve their UDA target for that financial year they may choose to give back a percentage of their UDAs to the Health Board. Handback may also occur if a dentist chooses to close their practice or if they retire for example.

2. These UDAs can then be auctioned back to dental practices within the Health Board, although this reinvestment does not always occur. In Betsi Cadwaladr for example there has been a net closure of 8 practices in the last three years with a knock-on effect on patient access.

Table 3: Clawback handback and contract reductions in all Health Boards over three-year period and resulting underspend.

Health Board	GDS Budget from 2014/2015-2016/2017 TOTAL	Clawback and handback from 2014/2015-2016/2017 TOTAL	Contract reduction from 2014/2015-2016/2017 TOTAL	GDS Spent from 2014/2015-2016/2017 TOTAL	Percent of budget unspent	Percent of equivalent budget (with contract reductions included) unspent
Betsi Cadwaladr	£83,507,000	£3,937,222	£318,382	£79,251,396	5.1%	5.5%
Cwm Taf	£49,375,173	£1,402,929	£252,305	£47,719,939	2.8%	3.3%
Cardiff and Vale	£76,747,000	£1,520,000	£216,827	£75,010,173	2.3%	2.5%
Powys Teaching	£15,426,215	£1,818,656	£616,952 (approx.)	£12,990,606	15.8%	19.0%
ABMU	£88,712,738	£2,724,903	£488,537	£85,499,297	3.6%	4.2%
Aneurin Bevan	£68,902,203	£1,704,983	£196,672	£67,000,548	2.8%	3.0%
Hywel Dda	£36,993,000	£3,213,770	£2,233,391	£31,545,383	14.7%	19.6%
Wales Total	**£419,663,329**	**£16,322,463**	**£4,323,066**	**£399,017,342**	**4.9%**	**5.9%**

Table 4: Number of practices which experienced clawback over a three-year period

Health Board	Number of Practices facing Clawback 2014-2015	Number of Practices facing Clawback 2015-2016	Number of Practices facing Clawback 2016-2017
Betsi Cadwaladr	35 (50%)	36 (51%)	35 (50%)
Powys Teaching	11 (55%)	12 (60%)	11 (50%)
Hywel Dda	7 (16%)	10 (23%)	8 (19%)
ABMU	32 (50%)	31 (48%)	17 (27%)
Cwm Taf	8 (28%)	13 (45%)	6 (21%)
Aneurin Bevan	16 (26%)	16 (26%)	21 (34%)
Cardiff and Vale	17 (21%)	26 (39%)	12 (18%)
All Wales	**126 (36%)**	**144 (41%)**	**110 (31%)**

Table 5: GDS contract reductions in each Health Board

Health Board	Number of Practices	Total Amount
Betsi Cadwaladr	18	£318,382
Powys Teaching	11	22884 UDAs (approx. £616,952)
Hywel Dda	20 (11 temporary)	£2,233,391 (£1,336,214 temporary)
ABMU	11	£488,537
Cwm Taf	7	£252,305
Aneurin Bevan	15	£196,672
Cardiff and Vale	12	£216,837

D) How are Clawback and Handback affecting Dentistry?

1. Clawback and Handback mean that the patient access issues being faced in Wales will only worsen, especially when two years of clawback in a practice results in permanent contract reduction.

2. Clawback and handback have resulted in millions of pounds that should be used for dentistry not being reinvested. **In the last three years alone £20 million has been taken out of NHS general dentistry in Wales due to clawback and contracts reductions**, but only a small fraction of this has been reinvested into dental practice facilities by one or two Health Boards.

3. To illustrate the loss of patient treatment resulting from clawback in 2015-2016:
   - The money clawed and handed back in Hywel Dda was equal to 51,348 Band one treatments; that is 37% of the Band 1 work Hywel Dda did that year.
   - In Cwm Taf 9,752 more Band two treatments could have been performed with the funds they clawed back.
   - A shocking 50% more Band 3 treatments could have been performed with the clawback in Hywel Dda if the funds had been reinvested.

4. The current system of clawback and handback only exacerbates the growing patient access problem because taking on new patients is a risk to dentists trying to achieve such tightly managed targets. Dentists are disincentivised in the current contract to treat high needs patients because there would be a significant financial loss to the practice.

5. Scaled up, a large proportion of high needs patients can result in a practice failing to reach its targets and facing clawback, handback or contract reduction despite the increased expense to the practice. This is a double negative impact – the loss of revenue and the higher costs of treatment.

6. Clawback is prevalent in all Health Boards, meaning that patients with poor oral health are disproportionately affected. *Inverse care law* is felt acutely in general dentistry.

7. Many overheads such as running a chair and employing staff are fixed commitments. Therefore, clawback and contract reduction have a direct impact on staff employment, particularly ancillary staff. Such a model will always work against the interests of high needs patients. This requires to be fundamentally changed.

8. There needs to be new thinking 'outside the box'. Clawback is pernicious, counter-productive and operates with a bureaucratic machinery. We welcome any advances within contract reform that help to use this money directly for the benefit of patients and the support of practices.
9. The cost of materials has been rising above inflation for many years, and now with the new environmental regulations concerning the use of mercury, amalgam use is being sharply reduced and the more expensive restoration materials used in its place. This will further strain an already broken business model.

10. There is a growing trend for practices to bought by corporates rather than early career dentists taking on their first practice ownership, because this is becoming prohibitively expensive for the majority. Yet corporate practices are finding that NHS contracts are unworkable and, after suffering clawback and contract reduction, are as a result closing in ever larger numbers. In one area alone there have been closures in Knighton, Machynlleth, Dolgellau and just recently Builth Wells. The latter is the corporate, 'MyDentist'. This matter of practice closures has been made clear to Welsh Government by dentists' representatives on several occasions, and yet in their most recent evidence to the DDRB the Welsh Government does not acknowledge there is a problem with provision of NHS dentistry services.

11. One dentist wrote to their AM and MP in 2017 to seek support for their practice situation as such pleas had fallen on deaf ears in the Health Board. This is a rural, single-handed dentist who could not recruit an associate in two years and had to give back their NHS contract in 2017. This extract sums up succinctly the very real problems that many dentists are facing throughout the country, and especially but not exclusively in the more rural areas.

> **"The NHS contract is a disgrace - it promises patients comprehensive care, but in reality, is so poorly resourced and constructed, that care takes place despite it. The current environment is simply not fit for purpose. On the ground, officials do care, and they do their best, but the system and available resources are grossly inadequate. Someone, somewhere, should be held accountable for the current situation. In the longer term, there has to be some integrity and honesty about what the state is prepared to provide through the NHS."**

12. There are similar comments from members who took part in our August survey:

> **"Everybody seems to agree that we should focus on prevention yet prevention is simply not 'recognized' in the UDA system as an 'activity' and therefore it is not remunerated. We are expected to deliver prevention to each and every one of our patients for free while trying to meet UDA targets in order to keep our practices afloat, and indeed, most of us are doing it because we care about our jobs and our patients, and the Government is taking this for granted.**
>
> **When are we going to look at the elephant in the room and see it for what it is: there hasn't been any new money going into NHS dentistry in the past 10 years, money is being taken away from us (through claw backs) and used to patch up holes in other NHS departments.**
> **NHS dental practices are struggling to survive, some are closing down and others are just about managing to break even, there is a huge recruitment crisis all over the country because the value of our work is not being recognized and the highly skilled work that we do is not fairly remunerated.**
>
> **I am not a pessimistic person and I love my job, but after 11 years working under the current NHS contract I fear for the future and frankly I'm expecting the worst."**

"The system needs to change. We are penalised when we see patients with high need. This is a disincentive to opening the books to new patients. It's also a ticking time bomb for the older generation with heavily restored mouths. The system will not recompense sufficiently to treat this considerable group, many of whom had the original treatment at different practices (and countries) years ago. So despite what the CDO may say I think oral health and dental care for the majority is on the slide unless we move away from a targeted based system and concentrate on patients need; which will vary between areas."

E) What is Contract Reform (and will it help)?

1. Contract reform has taken place in several different Government pilots in Wales since 2011 and the BDA Wales has endeavoured to be the Government's critical friend and a support to practices undertaking such pilots. Eight practices took part in the original scheme. Those taking part in the pilots favoured this new way of working and argued that whilst the UDA system focused on numbers, the pilot focused on people (capitation). This ethos of prevention was strengthened in the 2016 prototype contract run in two practices in Swansea which had no UDAs. However, although those two practices remain on that contract until today, the new CDO introduced a different type of pilot in 2017[4], based on the current contract of UDAs.

2. The new pilot in Wales has been running since September 2017 and operates based on 10% of UDAs used for data gathering of oral health needs assessments, which is the first small step to improving a patient's oral health. However, the BDA would like to see a much greater percentage of UDAs (at least 30%) being used for prevention to make it a workable prospect.

3. In an ideal world the BDA Wales would prefer all practices to be given the type of contract that the two prototype practices in Swansea are operating, which is 85% capitation and 15% quality measures. With such a contract no clawback is imposed, and preventative dentistry is at the front and centre of its operations. The 'prototype practices' saw an initial reduction in patient numbers at the early stages because preventative treatment is more resource intensive initially until the high needs patients are stabilized, but two years on and the most recent data show that patient access has returned to the required levels.

4. One of the key aspects of contract reform propounded by the Welsh Government is the use of skills-mix[18,19], which essentially is employing dental hygienists and therapists to take on some of the work usually done by dentists. (These DCPs might also be upskilled to optimise this arrangement.) The proposed theory is that in turn dentists would be freed to upskill to more specialist dentistry, thereby maximizing the use of their expertise and skills outside of the practice on an intermittent basis, making room for the DCP to work in their stead. This arrangement, together with extended recall times for patients with good oral health, would in theory allow capacity for increased access of patients. Whilst this appears to be a rational approach, we wonder if it is practicable. The BDA has requested from Welsh Government the business model that demonstrates how this skills-mix would work, particularly for single-chair dental practices.

5. There are many fixed overheads in running a dental surgery chair and apart from the salary differential (which is not a great saving) there are no other obvious savings to the practice. DCPs have a limited repertoire, even with the upskilling, and tend to be slower. Should the model needs an extra dental surgery chair for the DCPs it is unclear a) how this can be afforded by the

practice, b) how the return on investment (ROI) makes good business sense, and c) whether patients would be comfortable being seen by several different practitioners rather than just their dentist. In fact, the patient view is currently missing altogether from this model, although we trust the pilots will include this in the data collection. The BDA reports anecdotally that only a minority of dentists would be interested in upskilling and we would ask where the money for such training and the backfill would come from.

6. We were involved in the discussions that form the response[20] by the CDO to the Government's policy *A Healthier Wales*. However, we would like to see this fleshed out to include the critical financial, operational and cross-service reform considerations.

Appendix 4: Data showing dental activity over the last six years

Government data when computed as shown in table 6 demonstrate that the percentage of patients who are paying charges is rising much more steeply than the population increase.

Table 6: Comparison of courses of treatment, number of patients treated, patients charged and the total population between 2010-11 and 2016-17 (Data from Stats Wales)

Period	total courses of treatment	number of patients treated	Patients who paid charges	Population of Wales
2010-11	2,316,330	1,653,797	932,917	3, 050, 000
2016-17	2,383,391	1,710,254	1,071,298	3, 113, 000
Increase in six years (N)	67,000	56,457	138,381	63,000
Increase in six years (%)	2.9%	3.4%	**14.8%**	2.1%
Average yearly increase (%)	0.48%	0.57%	2.47%	0.35%

Appendix 5: Recruitment and Retention of Dentists

1 Substantial evidence of recruitment and retention problems was provided by the BDA to the last DDRB review, which included sections from Wales describing the knock-on effects of clawback on patient access - some of that clawback was a result of practices not being able to recruit associates. Nevertheless, the DDRB chose to ignore the collective UK BDA evidence describing it in July 2018 as anecdotal[21], and instead favoured the Governments' figures[19] that suggested that all was well with NHS dentistry. The official Welsh Government statistics, in their evidence to the DDRB, failed however to account for population growth which means that NHS dental activity as a percent of the Welsh population has remained stubbornly at 54% for the last 6 years. (*See Appendix 4*.)

2 The BDA Wales will be presenting new evidence to this year's DDRB suggesting that this percentage is likely to decrease in the near future with access now being very low for new patients, and with many practices now experiencing clawback and contract reductions, problems recruiting associates and more practices closing, including corporate practices such as MyDentist.

3 There have been several closures of MyDentist practices in England and Wales in the last few years, in many cases because of not being able to attract enough associates and because they operate a different business model to practitioner-owned practices and have not found dentistry profitable enough. Peter Ward, the CEO of the BDA, in 2017 pointed out, 'dentistry isn't the only area where the corporate "consolidators" have entered the fray.' This has happened in both pharmacy and optical services, but for them 'the clinical component of the income streams for both businesses is relatively small and the merchandising activity is vast.' Dentistry is different, in that 'the biggest part of what patients pay for is the dentistry itself – the actions of the clinically trained professionals.'

4 The BDA produced an extensive report on The State of General Dental Practice in 2013[22]. Section 16.2 states: "*Recruitment seems particularly difficult in Wales. Welsh associates have the highest pay of any region which probably reflects their difficulty in recruiting. Practice owner pay in Wales is much lower than that in the other countries. Welsh practice owners seem to be paying themselves less in order to engage associates to help meet their UDA targets*."

5 NHS Digital this month[7] said: "*Whilst the results for Associate dentists are quite similar when comparing England & Wales to Wales only, there are larger differences for Providing-Performer dentists where dentists in Wales tend to work longer hours, take fewer weeks' annual leave and perform more NHS work."*

6 NHS Digital[23] also reported that in 2016/17 Providing-Performer dentists' average taxable income from NHS and private dentistry decreased by 7.3%. Associate dentists have also seen a decrease in taxable income by 2.1%

7 The BDA Practice Owners Survey 2016 has shown that morale is low for Welsh dentists who perform mostly NHS dentistry, only 26% of whom feel they are fairly remunerated. [NHS Digital this month[7] said: "*The most common contributory factors to low morale are increasing expenses and/or declining income and the risk of litigation and the cost of indemnity fees. Regulations are also cited as a major cause of low morale amongst Principal dentists."]* Yet despite this long-running narrative from the BDA, the UK Governments appear impervious to these messages.

8 In the most recent statistics (August 2017) published by the Welsh Government it appears there has been little change in the number of dentists per 10,000 of the population. However, this figure does not consider the full-time equivalents (FTEs) providing NHS treatment and is merely a headcount. NHS Digital this month[7] said: *"During the last decade there has been a notable drop in the amount of time dentists spend on clinical work across the UK."* The FTEs will be therefore lower. Also, the figure 1,475 includes Dental Foundation Year 1 posts. We therefore believe this latest report does not paint the whole picture.

9 The last time the Welsh Government systematically considered workforce issues was the survey[24] of 2012. The review states that 'On average during the period 2007-2010, 58% of Welsh-trained dental graduates entered the Welsh workforce after completing DF1. Undertaking DF1 training in Wales is a significant factor in the decision to continue working in Wales. Of these (58%), 90% undertook DF1 training in Wales and 10% undertook it elsewhere before returning to work in Wales'.

10 The Dental School in Cardiff was set up in the main to increase the Welsh dental workforce, which it appeared to have done successfully in the initial graduate years from 1967. The 2012 workforce survey says that 'Welsh trained dentists account for 41% of the dentists currently working in Wales'. However, since then the picture of Foundation Training has been changing with the recent introduction of the centralised Foundation Training Application Process[24] which is UK-wide, and which means that trainees cannot be guaranteed which country, let alone which county, they will be assigned to. This has a high risk of creating a highly volatile post-training workforce and with no guarantee that Welsh-born dentists will feel a strong imperative to return to Wales.

Appendix 6: Orthodontic services

Table 7 shows the most recent data available from FOIs[13] in 2014 as well as a comparison to each Health Boards population. Cardiff and Vale, Betsi Cadwaladr and Powys were handling orthodontic waiting lists 3-5 times better than Hywel Dda. Moreover, ABMU and Aneurin Bevan were handling orthodontic waiting lists 20 to 40 times better. It should be noted that while this figure may show ABMU to be coping well, we are aware that there are difficulties within the orthodontic services in ABMU. The Review[26] of the orthodontic services in Wales 2008-09 to 2015-16 stated that a strategy needed to be developed for the future of Orthodontic services. The Strategic Advisory Forum on Orthodontics reports[27] periodically to the CDO on progress.

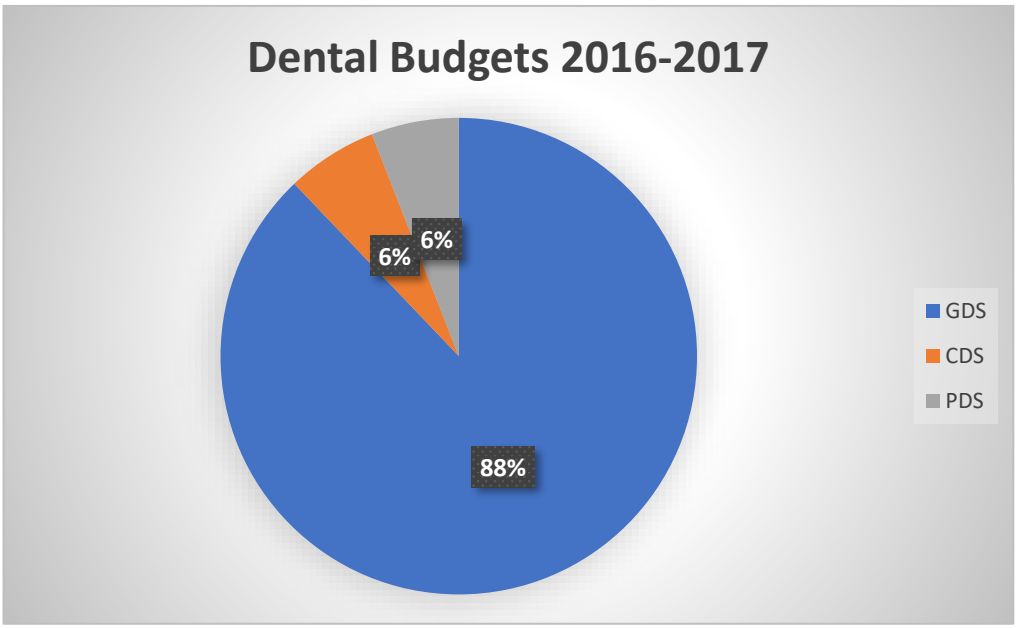
Table 7: Waiting list numbers for orthodontic services in 2014 for each Health Board

Health Board	Waiting list in 2014	Population aged 0-15 in 2014	Percentage of 0-15 Population
Hywel Dda	1584	65,236	2.40%
Cardiff and Vale & Cwm Taf	1019	144,193	0.70%
Betsi Cadwaladr	769	123,699	0.62%
Powys	100	21,919	0.45%
ABMU	83	91,439	0.09%
Aneurin Bevan	73	108,355	0.06%

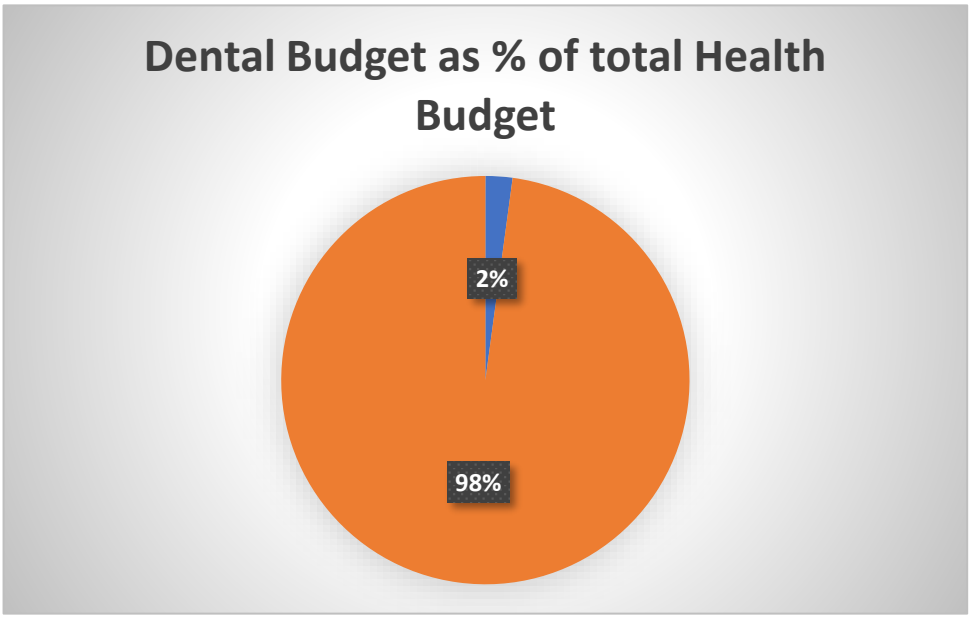
Table 8: PDS Budgets for 2014-15 to 2016-17

PDS Budgets	2014/2015	2015/2016	2016/2017
Betsi Cadwaladr	Not separate from GDS		
Powys Teaching	£521,611	£747,219	£966,115
Hywel Dda	£1,516,289	£1,550,786	£1,606,696
Cwm Taf	£168,804	£171,066	£172,948
Aneurin Bevan	£4,543,509	£2,484,571	£2,657,592
ABMU	Does not hold this information		
Cardiff and Vale	Have not responded		
4 HBs total	**£6,750,213**	**£4,953,642**	**£5,403,351**
Estimated Total	**£11,812,872**	**£8,668,873**	**£9,455,864**

Appendix 7: Comparison of GDS, CDS and PDS budgets 2016-2017



*The figure for PDS required estimation



Total Health, Well-being and Sport Budget £7,291,241,000 (2018-2019 figures)

Appendix 8: Oral health programmes in Wales

1. Cwm Taf Health Board[28] runs the scheme *Baby Teeth Do Matter* which works with GP practices and other health care professionals to promote the oral health of children, particularly those age 0-2 and 3-5. This scheme has seen an increase of 42% of children attending dental appointments in the Merthyr locality. There has also been a significant 70% increase of children aged 0-2 visiting the dentist. Cwm Taf also runs its own tooth brushing scheme. This scheme employs oral health educators to visit 38 schools in Cwm Taf. Now, only 15 schools in Cwm Taf don't participate in a tooth brushing scheme.

2. The CDS-run *Designed to Smile* (D2S) scheme has enjoyed some successes such as a tooth decay prevalence falling by 12% among five-year olds[29]. The scheme costs approx £4m per annum to run[30]. D2S has had a recent refocus[31] to include children 0 to 3 yrs old, as it is extremely important to include this age group. However, this refocus of D2S now excludes children from fluoride varnish treatment just as their permanent teeth arrive and offers over 5's only tooth brushing. These children are expected to receive fluoride varnish in the GDS instead. Currently 66% of children visit a NHS dentist, leaving 34% who do not. Given the very low access for new children in many parts of Wales, the number of children treated in future is likely to go down not up. Therefore, this refocus is a gamble as it could greatly impact their future oral health. The BDA has previously called for additional funding of approximately £2m per annum to maintain their inclusion. One third of the GDS clawback would cover this.

3. Since the National Assembly for Wales Children and Young People Committee Inquiry[32] into children's oral health in 2012 there has been some notable progress against the various recommendations put by the committee. However, without a modest increase in investment (from GDS clawback money) this programme will not reap all the rewards that are potentially there for children's oral health improvements.

Appendix 9: Glossary of Terms

Name/Acronym	Explanation
Amalgam	Dental amalgam is a liquid mercury and metal alloy mixture used in dentistry to fill cavities caused by tooth decay.
Associate	Dentists who contract with dental practices to provide general dentistry services
CDO	Chief Dental Officer
Clawback	Money deducted from the practice by the Health Board when fewer than 95% target UDAs are achieved
Corporate Dental Practice	Corporate bodies are a relatively new phenomenon in dentistry; it is only 12 years since the GDC removed restrictions on the number of 'Bodies Corporate' who could operate. Cynically, there is an argument for the NHS to commission NHS dental contracts from a handful of large corporates rather than thousands of small independent practices. However, the impact of large dental corporates has not been a positive one. The largest group is currently "MyDentist", the second largest is BUPA/Oasis. Both of these large players have struggled to grow smoothly and profitably and have found it hard to recruit dentists to work for them, particularly in rural areas. This and other problems led to MyDentist bringing its acquisition campaign to a halt, and then to start selling off some practices.
D2S	The CDS-run Designed to Smile Oral Health Programme in Wales
DCP	Dental Care Professional - includes dental therapists, hygienists, dental nurses, oral health educators
DDRB	Doctors and Dentists Pay Review Body
LDC	Local Dental Committees were set up in 1948, at the inception of the NHS. In England and Wales, provision in statute has been made for them to be recognised and consulted since the NHS Act 1977. Local NHS representatives may consult with LDCs on any matters of local dental interest.
National Survey for Wales	Each year the National Survey for Wales involves over 11,000 people across Wales. From 2016-17 the National Survey replaced the 2012-15 National Survey, the Welsh Health Survey, Active Adults Survey, Arts in Wales Survey, and Welsh Outdoor Recreation Survey, as agreed by Cabinet in 2014.
PCR	Patient charge revenue. Contrary to public perception the dental practice does not keep this money. It is returned to the Health Board. The BDA Wales would like to see patient charges frozen or restructured as they are a tax that involves a lot of bureaucracy and which acts as a deterrent to patients who are not eligible for benefits but are on lower incomes.
Pilot	A variant of the 2006 contract being trialed for a set period of time in selected dental practices. Different pilots have been running since 2011. Variation can be as little as 10% UDA for preventative work up to 85% of UDAs. The current Welsh pilot is 10% UDAs for oral health needs assessment data recording only.
Poor Oral Health Impact	The Global Burden of Disease study[33] (2010) found that most disability amongst 5 to 9 year olds in the UK was caused by poor oral health. An average of 2.24 hours of children's healthy lives was lost for every child aged 5 to 9 years because of poor oral health. This exceeded the level of disability associated with vision loss (1.64 hours), hearing loss (1.77 hours) and type 2 diabetes (1.54 hours).
Providing-performers	NHS Contract holders who also perform NHS dentistry
UDA	Unit of Dental Activity
UOA	Unit of Orthodontic Activity

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The Welsh Assembly's Health, Social Care and Sport Committee
Inquiry into Dentistry in Wales 2018

Response by the BDA Wales
"More than Words"

Report submitted on 30 August 2018

Dr Caroline Seddon
National Director BDA Wales
Report Editor

BDA Wales has a policy of publishing key documents in Welsh and English (see our website)
https://www.bda.org/bdawales

Due to the time constraints of this consultation, it was not possible to translate this response into Welsh.

Agenda Item 3

British Orthodontic Society (BOS) Submission to the National Assembly for Wales Health, Social Care and Sport Committee's Inquiry into Dentistry in Wales.

Author: Mr. Benjamin R.K. Lewis, Consultant Orthodontist.

Background

The British Orthodontic Society (BOS) is a charity that aims to promote the study and practice of orthodontics, maintain and improve professional standards in orthodontics, and encourage research and education in orthodontics.

The BOS is also a representative body of all branches of general dentists and specialist orthodontists in the UK who provide orthodontic care. The Groups within the Society are the Orthodontic Specialists Group, Practitioner Group, Community Group, Consultant Orthodontist Group, University Teachers Group and the Training Grades Group.

Orthodontics is the dental specialty concerned with facial growth; the development of the dentition and occlusion; and the assessment, diagnosis and treatment of malocclusions and facial irregularities.

Orthodontic treatment provided by the National Health Service (NHS) is undertaken according to clinical need as determined by the Index of Orthodontic Treatment Need (IOTN).

Orthodontic treatment is recognised to have a range of health benefits including the reducing the risk of dental trauma from prominent teeth; reducing the risk of root resorption of adjacent teeth from impacted teeth; recreation of space for the replacement of missing teeth or eliminating the space completely to reduce the restorative burden in the future; improving the ability to clean the teeth and reducing the risk of dental caries; improving dental function; and correcting dento-facial deformity .

One must consider the definition of health in its entirety as promoted by the World Health Organisation: "Health is a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity."

With this in mind, in addition to the dental health benefits highlighted above, there is also an improvement in the appearance, self-esteem and psychological well being, which can be especially important during the formative years of adolescence.

Orthodontic provision in Wales is undertaken by a range of professionals: Orthodontic Therapists (under supervision), Dentists with Enhanced Skills (DES)/Dentists with Special Interest (DwSI) in Orthodontics; and Orthodontic Specialists; in a range of clinical environments: General Dental Practice; Specialist Orthodontic Practice; Community Dental Clinics; District General Hospitals; and Cardiff University Dental Hospital. Who undertakes an individual's orthodontic treatment is determined by the complexity of the malocclusion and

the treatment required; any additional dental, medical and social needs of the individual; and the availability of the required expertise within the geographical area.

To date there have been three major documents produced with regards to orthodontic provision by the National Assembly for Wales:

- National Assembly for Wales Health, Wellbeing and Local Government Committee – Orthodontic Services in Wales, February 2011
- National Assembly for Wales Health and Social Care Committee – Orthodontic Services in Wales, July 2014
- "Review of the Orthodontic Services in Wales 2008-09 to 2015-16." (Professor Richmond 14/12/16). This document supersedes the Professor Richmond's previous "Review of the Orthodontic Services in Wales 2013-14." (Professor Richmond 06/02/15)

With regards to the current Inquiry, the BOS have been asked to comment of the following areas:

1) Progress made to improve the efficiency of orthodontic services delivered in Wales, with reference to the recommendations of the previous reports.
2) Training, recruitment and retention of the orthodontic workforce
3) Waiting times for appointments and treatment.

1. Progress made to improve the efficiency of orthodontic services delivered in Wales, with reference to the recommendations of the previous reports.

The recommendations from the previous reports are detailed below with the subsequent action, as far as the Society is aware, that has been undertaken detailed in bold.

<u>National Assembly for Wales Health, Wellbeing and Local Government Committee Report on Orthodontic Services in Wales (February 2011) made the following recommendations:</u>

Recommendation 1. We recommend that the Welsh Government commissions further research to assess the orthodontic treatment need, ensuring that contracts for orthodontic treatment are adequate to meet demand.

Action: We are not aware of any Research in this area commissioned by Welsh Government. It is, however, established best practice, that before any procurement procedure, a Needs

Assessment is undertaken within that area, with input from all professional stakeholders and representative bodies, to fully assess the local requirements.

Recommendation 2. We recommend that Local Health Boards improve the efficiency and effectiveness of orthodontic services delivery through effective procurement processes. This should include ensuring that contracts contain details about the number of treatment starts and treatment completes per year in each contract.

Action: Key Performance Indicators (KPI) form part of the Contracts issued to Orthodontic Providers. The exact nature and wording of the KPIs will be determined by the LHBs, who will take into consideration the steer of Welsh Government via the following document:

"Updated guidance: Delivery of orthodontics in primary care – November 2015".

Recommendation 3. We recommend that the Welsh Government produces guidance for Local Health Boards on the effective and efficient procurement of orthodontic services. This should include guidance on developing agreements based on the number of treatments provided per year, quality of services, orthodontic treatment outcomes and value for money.

Action: Welsh Government issued the following documents:

"Guidance on Management of NHS Orthodontic Contracts in Primary Dental Care – July 2013"

"Updated guidance: Delivery of orthodontics in primary care – November 2015"

Recommendation 4. We recommend that the Welsh Government discusses with the Welsh Consultant Orthodontic Group how to introduce standardised UOA rate to address the disparity in UOA value and volume of treatment provided.

Action: Not undertaken.

Recommendation 5. We recommend that Local Health Boards review contracts identified as delivering orthodontic assessments only or mainly assessments and very few treatments.

Action: We believe that the LHBs have identified and eliminated Providers who were delivering assessment only contracts.

Recommendation 6. We recommend that Local Health Boards introduce specific contractual changes to take account of treatment provided rather than just delivery of UOAs. This should include consideration of whether practitioners should be allowed to claim for a repeat assessment within a short period of time unless it is clinically justified.

Action: We believe that the LHBs have introduced variations to the KPIs which have stipulated the recommended ratios between different types of claim in accordance with the Guidance documents issued by Welsh Government. Any variations from the average by individual providers is automatically highlighted to the LHBs and these will be discussed as the routine contract review or at an earlier meeting if necessary.

Recommendation 7. We recommend that the Welsh Government facilitates the development of an electronic referral system in line with Recommendation 6 of the Government's national review, which will allow records to be monitored centrally.

Action: The Electronic Referral Management System (eRMS) for all Dental Referrals has been commissioned following an open tendering process by Welsh Government. The eRMS is currently under construction with expected phased roll out to the LHBs toward the end of 2018 and into 2019.

Recommendation 8. We recommend that Local Health Boards support the establishment of local Managed Clinical Networks (MCNs) in orthodontics with the view of improving patient care. MCNs should take lead responsibility for reducing early, multiple and inappropriate referrals in line with Recommendation 12 of the Government's national review.

Action: Orthodontic MCNs have been established in North Wales & Powys, South East Wales and South West Wales. The MCNs input into their local Oral Health Strategy Groups as well as having representation on the Welsh Government's Strategic Advisory Forum in Orthodontics. All MCNs have established local referral proformas and criteria to improve the quality of referrals as well as leading the way with regards to quality and safety within their regions.

For MCNs to operate efficiently, it is essential that they have full engagement from all the relevant stakeholders within the Profession and the HB. This is never more important when considering policy introduction that will have a profound effect on local service provision such as appeals processes and retendering of services.

The three Welsh MCNs have also liaised to produce a National Orthodontic Referral Form which has formed the basis for the orthodontic section of the forthcoming All Wales Electronic Referral Management System and a number of orthodontic electronic referral systems in England.

Recommendation 9. We recommend that the Welsh Government funds a one off waiting list initiative to clear the backlog of patients waiting for orthodontic treatment.

Action: Not undertaken.

Recommendation 10. We recommend that the Welsh Government discusses with the General Dental Council how to ensure that the issue of inappropriate referrals is addressed and whether IOTN training should be mandatory for all GDPs.

Action: No information available as to whether this has been undertaken.

Recommendation 11. We recommend that the Welsh Government amends Regulations to include a contract penalty for practitioners who persistently refer patients early or making a high volume of inappropriate referrals in order to encourage them to change practice.

Action: Not undertaken

Recommendation 12. We recommend that Local Health Boards set out clear contractual arrangements with DwSIs including close monitoring of treatment outcomes, with a view to the development of specific orthodontic Personal Dental Services agreements.

Action: DwSIs should be monitored to the same level with the same expectations of the outcome as orthodontic specialists (although the range and complexity of cases they have undertaken will be inevitably reduced). It would be anticipated that DwSi, who are only treating patients from their own Practice, should be using a higher proportion of their allocated UOAs, if not all their allocated UOAs for treatment, as any reviews before treatment is commenced would be undertaken with their General Dental Practitioner "hat" on.

Recommendation 13. We recommend that Local Health Boards work with local MCNs to introduce a local accreditation scheme and continuing professional development for DwSIs.

Action: Accreditation schemes have been undertaken by all three MCNs, each with variations to accommodate local circumstances, but underpinned by a tripartite agreement that all orthodontic treatment plans should be undertaken by an orthodontic specialist.

Recommendation 14. We recommend that the Welsh Government facilitates the development of the skills base of the orthodontic workforce.

Action: No information available as to whether this has been undertaken.

Recommendation 15. We recommend that the Welsh Government strengthens the current General Dental Council guidance to ensure orthodontic therapists must be supervised by an orthodontist on the specialist register as opposed to a general practitioner at all times.

Action: No information available as to whether this has been undertaken at a Welsh Government level, however modifications to the required level of supervision of orthodontic therapists have been included in Contracts issued in North Wales following the PDS Specialist Orthodontic Contract re-tendering process. In addition, it has been agreed by the Strategic Advisory Forum in Orthodontics that the BOS Guidelines on supervision of Qualified Orthodontic Therapists 2017 should act as the <u>minimum</u> standard as this document also uses the term "dentist" as many areas of the UK do not have Accreditation Schemes for DESs/DwSIs.

Recommendation 16. We recommend that the Welsh Government amends Regulations to include a contract penalty for poor quality treatment (based on PAR and excluding those cases where the patient was not compliant with the treatment).

Action: No information available as to whether this has been undertaken.

Recommendation 17. We recommend that the Welsh Government develops an implementation process to facilitate close monitoring of treatment outcomes through PAR and establish a system where PAR score reductions are monitored independently on annual basis for all providers.

Action: No information available as to whether this has been undertaken at a Welsh Government level, however within each MCN area, Peer Assessment Rating (PAR) score monitoring is undertaken instigated by either the Local Orthodontic Committee (LOC), MCN or HB.

National Assembly for Wales Health and Social Care Committee Report on Orthodontic Services in Wales (July 2014) made the following recommendations:

Recommendation 1. The Committee recommends that the Minister for Health and Social Services works with local health boards and managed clinical networks to develop robust monitoring arrangements to ensure consistent compliance with treatment outcome requirements.

Action: PAR score audits are undertaken within all MCN areas. These are conducted by either the LOC, MCN or HB. It is essential that all practitioners with responsibility for the treatment outcome are included and judged to the same standards, accepting that PAR is not designed to assess the outcome of certain malocclusion types.

Recommendation 2. The Committee recommends that the Minister for Health and Social Services confirms when the electronic referral system will be introduced, and sets out the actions local health boards and managed clinical networks can take to identify patterns of inappropriate referrals, and plan and deliver suitable targeted interventions.

Action: The Electronic Referral Management System for all Dental Referrals is currently under construction and is due to be rolled out 2018/2019.

Recommendation 3. The Committee recommends that the Minister for Health and Social Services sets out the actions local health boards and managed clinical networks can take, with associated timescales, to improve waiting times in each local health board area, and identifies the monitoring arrangements he will put in place.

Action: No information available as to whether this has been undertaken.

Recommendation 4. The Committee recommends that, to ensure that the service received by patients is of a sufficient standard, the guidance issued to local health boards by the Chief Dental Officer in relation to commissioning orthodontic services includes best practice for the establishment and monitoring of such services.

Action: This is included within the Welsh Government's document: "Updated guidance: Delivery of orthodontics in primary care – November 2015"

Recommendation 5. The Committee recommends that the Minister for Health and Social Services takes steps to reform payment arrangements for orthodontic services to address the concerns raised by the Committee.

Action: This has not been undertaken. Retendering of Specialist Primary Care Contracts within Wales is currently ongoing. However, different approaches have been taken by the different Health Boards. It was highlighted in this report how important it was that Practices

have the "confidence to invest" with longer term contracts. However, it is also essential that any new contractual arrangements are viable, as there is concern that new UOA rates that do not take into account local circumstances and National requirements will pose a risk to the long term sustainability of Specialist Practice and the associated service provision.

Recommendation 6. The Committee recommends that the Minister for Health and Social Services reviews the guidance available to support local health boards in entering into contracts for the provision of orthodontic services which take local needs into account. Such guidance should cover, as a minimum, determination of contract length, robust performance and quality monitoring arrangements, protections against the selling on of contracts, and contract exit arrangements.

Action: See concerns raised above.

Review of the Orthodontic Services in Wales 2008-09 to 2015-16. (Professor Richmond 14/12/16)

Recommendations:

Welsh Government

• The Welsh Government in association with the various dental authorities and the Orthodontic Strategic Advisory Forum should lay out a clear strategy for orthodontics in Wales for the next 5 years. This should incorporate:

i. The personnel (skill mix) who should deliver care (GDP, Practitioners with a special interest in orthodontics, Specialist practitioners, Specialist/Orthodontic therapists
ii. The setting of the delivery (PDS, Hospital, Community, Private) and treatment thresholds with defined numbers requiring multiple dental/medical specialty treatments.
iii. Pragmatic patient access and coverage of orthodontic provision across Wales
iv. The type and quantity of orthodontic cases treated in the various settings.
v. Encourage contracts that are purely treatment driven to ensure equity and fairness for all Performers across Wales.

Action: It is believed that this work is ongoing, but yet at a relatively early stage in the process.

• Promote improved communication in Health Board decisions and local implementations of any local orthodontic decision/strategy.

Action: This can be achieved by a fully functioning MCN, however, as has previously been mentioned, for an MCN to operate efficiently it requires full engagement of all the relevant

stakeholders from within the Profession and the HB working together in an environment of mutual respect and cooperation.

• Facilitate improvement of data sharing and ensure robust systems for data recording/reporting with regard to all aspects of orthodontic provision in all provider settings.

Action: We are unaware as to how much progress has been made within this area.

Health Boards

• Orthodontic contracts should be based on "Assess and accept" only.

Action: Orthodontic provision includes both advice and treatment. To alter the renumeration system to cover only treatment would be unfair to the practitioners and a retrograde step.

• The practice of "Assess and review" should cease unless there is a clear indication.

Action: There are clinical circumstances where a further review, prior to commencing treatment, following an initial assessment, is entirely appropriate. To prevent inappropriate levels of "Assess and Review" the HB Contracting Teams have put into place expected ratios, outside which further investigations will be triggered.

• Ensure that there are contracts that reflect population provision in each Unitary authority and cross border flows are fully accounted for with robust pre-determined contracts.

Action: This should be established by a local "Needs Assessment". However, there is concern that the calculations of need based on a third of 12 year olds within an area can underestimate the actual local demand in practice. It is also essential that cross border activity, both between HBs and between Wales and England are full appreciated by those undertaking any "Needs Assessment" and are taken into account fully when considering any changes in policy.

• The Health Boards should monitor the performers according to key performance indicators, specifically the number of patient receiving active orthodontic treatment and whether these patients fulfil the orthodontic entry requirements as well as assess the outcome of treatments assessed by the PAR Index.

Action: We believe that these processes are in place within each HB. However, there are anecdotal reports that the level of monitoring by the HB can vary between different Providers within a HB.

• The number of Performers in each Health Board should match the likely need of the local population (as close as possible to expected numbers) and/or needs of the population in nearby Unitary authorities in other Health Boards.

Action: It must be recognised that it is the "whole time equivalent" number of performers that is most important to match rather than the actual number of performers. This will then be more able to reflect variations in working patterns and professional demographics. It is also essential that any cross border activity, and appropriate supervision of non-specialist orthodontic performers, is taken into account when calculating the "ideal" numbers.

• The data obtained relating to orthodontic treatment in the GDS/PDS is improving. More resources should be allocated to document orthodontic provision in other settings.

Action: We are not aware that this has occurred.

Orthodontic providers/performers

• Performers should routinely accept patients above the orthodontic treatment threshold and deliver average treatment outcomes consistent with 70% reduction in PAR scores

Action: All practitioners should only accept patients for treatment who qualify for NHS Orthodontic treatment according to the current threshold of IOTN. All completed treatment should be competed to a satisfactory standard as stipulated within the PAR guidance.

• Waiting list data (specifically date of birth, post code and date placed on waiting list) should be routinely collected and reported annually to the Health Boards.

Action: This should be available following the introduction of the Electronic Referral Management System.

• Re-treatments should be undertaken through the private sector.

Action: It is accepted that only one course of definitive treatment should be provided by the NHS to an individual patient, unless there were exceptional extenuating circumstances which the HB felt justified a second course of NHS funded treatment.

2. Training, recruitment and retention of the orthodontic workforce

The Orthodontic workforce undergo a variety of training pathways. These are summarised below:

Orthodontic Therapist – Dental Nurses who undertake a 12 month course cumulating in an exit examination by one of the Royal College of Surgeons.

Dentists with Extended Skills (DESs) / Dentists with Special Interest in Orthodontics (DwSI) – Dentally qualified practitioners who have experience in orthodontic management, often having training in posts which are not monitored or approved by the Specialist Advisory

Committee (SAC). In Wales, these individuals will then have been formally assessed by the DwSI Accreditation Process established by each MCN.

Orthodontic Specialist Practitioner – Dentally qualified practitioner who has undertaken a number of years training in related specialties such as Paediatric dentistry, oral and maxillofacial surgery, before embarking, via competitive entry, on a 3 year Orthodontic Specialty Training Pathway (StR 1-3) recognised by the SAC which also includes undertaking a taught postgraduate qualification such as a Masters or Doctorate. This cumulates in an exit examination by one of the Royal Colleges.

Consultant Orthodontist – Dentally qualified practitioner who has undertaken the Specialty training detailed above to become a Orthodontic Specialist Practitioner and then embarks, via competitive entry, on a SAC approved higher training pathway lasting from 2 to 2 ½ years (StR 4-5). This additional training focuses on the multi-disciplinary care that is the mainstay of secondary care orthodontic provision, but also provides training in the wider remit of an orthodontic consultant. This cumulates in an exit intercollegiate examination by the Royal Colleges.

It is recognised that throughout the UK, the more rural the environment, the harder it is to recruit suitably trained professionals. This is due to a number of factors, with two of the most important being where an individual's family/social connections are based, and secondly, that professionals tend to "settle down" near to where they trained due to the personal and professional links they established during their training period. The Welsh Orthodontic Training Programme is provided by Cardiff University which introduces logistical challenges to undertaken orthodontic training posts within North Wales. The Welsh Deanery have been very supportive of orthodontic training in North Wales, recognising its importance in recruitment and retention locally. A pragmatic solution has been agreed between the Welsh Deanery and Liverpool Orthodontic Training Programme to allow orthodontic trainees in North Wales to obtain their education element as well as some clinical training within Liverpool University Dental Hospital and Alder Hey Children's Hospital.

The main Orthodontic Training Programme in Wales is run via Cardiff University. All trainees undergo competitive entry via National Recruitment. The potential trainee ranks each available post and they are matched depending on their performance during the National Recruitment Process. Unfortunately, this system has resulted in some unintended consequences as it has been reported that trainees, who have a local connection to Wales and a desire to remain in the region in the long term, have not secured training places in these areas. This has lead to increased challenges in recruitment of specialists in Wales following completion of their training. Discussions have been held about the regional benefits of undertaking a recruitment process outside National Recruitment. In an attempt to improved Consultant recruitment, run through training has been established where a trainee undertakes both the Specialist Orthodontic Practitioner and Consultant Orthodontist training in succession within the same Region over a 5 year period. There are currently 4 "run through"

trainees in post and it is hoped that they will continue through to the completion of the Consultant training. Unfortunately, in other regions with “run through” training pathway, some trainees have stopped their training after the end of the Specialist Orthodontic Practitioner training period rather than completing their Consultant training, so it will need to be seen if the new policy increases the prospects of successful Consultant Orthodontic recruitment in due course.

For 2018 intake there have been two Orthodontic Specialist Trainees recruited (StR 1-3), one in South Wales and one in North Wales. Only one higher trainee (StR 4-5) was appointed out of 3 posts which were advertised. There is currently no Orthodontic Therapist Course being run in South Wales.

Another issue which has been raised as a potential barrier for trainees to accept orthodontic training posts within Wales is the differential payscales between England and Wales and the varying costs of the University fees to undertake the Orthodontic academic postgraduate qualification as Cardiff University reportedly has one of the highest course fees. This can lead to an income differential of £23,000 per annum between a trainee in England and Wales.

The issues with training along with the topography and rural nature of Wales has resulting in significant problems in recruitment and retention of certain sections of the orthodontic workforce. Within Primary Care Specialist Orthodontic Practice, some issues with regards the recruitment of Specialist orthodontists has been reported. There is a tendency for this to more common with Corporate Bodies as they can have a higher turnover of staff as well as the orthodontic performers not having a financial investment within the Practice. Within secondary care, the problem is more acute. This is due to numerous factors including issues of supply and demand, with at least 48 unfilled consultant posts within the UK, the tendency of newly appointed consultants to work part time, decreased uptake of Consultant training positions, and the inability of some posts to offer the prospect of a fully integrated Multi-Disciplinary Team and teaching opportunities, due to vacancies in other areas.

Table 1 Current Vacancies by Health Board

Health Board	Vacant Post(s)
ABMU (including Hywel Dda)	1wte Consultant 2 x post CCST (x3 attempts to recruit)
BCUHB	0.5 wte Consultant (YGC) 0.6 wte SAS (YMW & YG)
Cardiff and Vale	1.4 wte Consultant

Table 2 Further additional Vacancies from retirements in the next 5 years by Health Board

Health Board	Vacant Post(s)
ABMU (including Hywel Dda)	1 wte Consultant
Aneurin Bevan	None envisaged
BCUHB	1.2 wte Consultant (YG)
Cwm Taf	1.1 wte Consultant 1 wte CDS Post
Cardiff and Vale	None Envisaged

3. Waiting times for appointments and treatment

Waiting times within an area will be determined by a number of factors including the following:

I. Treatment Need
II. Treatment Demand
III. Commissioned Activity
IV. Availability of suitably trained professionals
V. Geographical influences
VI. Overall dental health
VII. Levels of deprivation

I. Treatment Need

An estimate of the treatment need can be calculated using a recognised traditional formula of a third of 12 year olds. However, as has been eluded to above, there is some evidence that this frequently used ratio can underestimate the actual treatment need in practice. The 2003 Child Dental Health Survey revealed that 8% of 12 year old and 14% of 15 years were undergoing orthodontic treatment and that a **further** 35% of 12 year olds and 21% of 15 year olds were assessed as having a treatment need. This equated to a recognised treatment need in 43% of 12 year olds and 35% of 15 years old. In addition, even this data is likely to underestimate the true treatment need as the "need" in the Survey was qualified as IOTN Dental Health Component of Grades 4 and 5 or an Aesthetic Component of 8-10, which is higher that the threshold currently in use for the allocation of NHS resources.

II. Treatment Demand

The perception of body and dental image has radically changed over the last 20 years and along with it the acceptance of undergoing orthodontic treatment. This has led to a substantial increase in the demand for orthodontic treatment. Fortunately, the strict adherence to only providing NHS orthodontic treatment to those to qualify according to the IOTN criteria, means that precious NHS resources are only used on those individuals with the greatest clinical need.

III. Commissioned Activity

The majority of current orthodontic activity is based on the historical distribution that was in place when the “New Contract” was introduced in 2006. The level of activity was determined by the orthodontic activity that had been carried out previously rather than what was required by the needs of the local populous. A number of HBs have commissioned “Needs Assessments” along with additional activity to address any discrepancies identified, however, the accumulated “back log” of individuals waiting for an orthodontic assessment and possible treatment has never been addressed.

IV. Availability of suitably trained professionals

It is recognised that throughout the UK, the more rural the environment, the harder it is to recruit suitably trained professionals. This is due to a number of factors, with two of the most important being where an individual’s family/social connections are based, and secondly, that professionals tend to “settle down” near to where they trained due to the personal and professional links they established during their training period (See section 3). Wales has additional challenges due to its topography and ignorance and misperception surrounding potential linguistic challenges.

V. Geographical influences

The topography of Wales with the associate transport infrastructure have a substantial influence on accessing Specialist care for those individuals who reside in the most rural areas. As most Specialist provision is based in areas of high population density, the provision of Orthodontic Treatment by outreach programmes such as the Community Dental Service or within the General Dental Service by DwSI/DESs is an important component of overall service provision in remote areas.

VI. Overall dental health

Orthodontic treatment can only be undertaken on individuals who have a stable dental health. In fact, the desire to undertaken orthodontic treatment can often be a very compelling motivator for individuals to change their behaviour to establish a good level of dental health. As this change is often permanent, it reduces general dental treatment needs for those individuals in the future resulting in a cost saving for the NHS over the long term. As the general dental health of the population improves following improved dental education and excellent interventions, such as “Design to Smile”, then the proportion of children with a recognised need for orthodontic intervention, as identified by IOTN, who now demonstrate a level of dental health sufficient to support a course of orthodontic treatment increases. This subsequently increase demand.

VII. Levels of deprivation

Deprivation levels will have a bearing on accessing orthodontic provision in a number of ways including suitability, due to poor levels of dental health, and transport limitations. As general dental interventions targeted at this demographic have a positive effect then access to treatment is improved.

Within Wales there are substantial waiting times for orthodontic assessments and treatment. Not every individual who has an orthodontic assessment will go on to have NHS orthodontic treatment. This can be for a number of reasons including general dental health, patient motivation/compliance to undertaking a prescribed treatment, personal circumstances, and not reaching the qualifying criteria according to IOTN.

The processes of managing referrals varies between providers. In general, in primary care, when a patient is referred, they are placed on a “waiting list” for assessment and possible treatment and are then taken off this list when a “treatment slot” becomes available. This results in a long referral to assessment time, but a short assessment to treatment time.

In secondary care settings, the patients are usually seen within 26 weeks from initial referral for a New Patient Assessment, as the Referral To Treatment (RTT) is only applicable for that initial assessment and then the patients are either discharged with advice, referred to another discipline/primary care specialist as appropriate, added to a treatment waiting list or reviewed depending on the clinical circumstances. This results in a relatively short referral to assessment time, but a much longer assessment to treatment time.

There is a concern about the identification of individuals who would benefit from “priority” orthodontic assessment and intervention, such as impacted teeth causing damage to adjacent teeth. This will be improved by the introduction of the eRMS as this will help identify these individuals, although it is recognised that any identification process is only as good as the referral information provided. Consideration has been given to altering the referral management process in Primary care to the secondary care model with patients experiencing a shorter Referral to Assessment time and if appropriate then being added to a longer assessment to treatment time, however, due to the current back log of patients waiting for the initial assessment, this would have implications on orthodontic treatment activity.

The current waiting times within both Primary and secondary care sectors is a result of historic and current discrepancy between referrals/need for treatment and actual treatment capacity.

The current orthodontic waiting times within Wales are reported as follows:

Table 3 Waiting times in primary care by Health Board

Local Health Board	New Patient Waiting Times (RTT)	Treatment Waiting Times after NP Assessment
ABMU (including Hywel Dda)	3-48 months	2 months
Aneurin Bevan	3-30 months	2-24months
BCUHB	8-10 weeks 16-24 months	18 months 2 months
Cardiff and Vale	6-30 months	2-6 months
Cwm Taf	17 weeks 6-22 months	6-15 months 2 months
Powys	4-12 weeks	2 months

Table 4 Waiting times in secondary care by Health Board

Local Health Board	New Patient Waiting Times (RTT)	Treatment Waiting Times after NP Assessment
ABMU (including Hywel Dda)	4-13 weeks according to urgency	In excess of 48 months
Aneurin Bevan	Up to 26 weeks (2 units)	54 months
BCUHB	20-26 weeks (3 units)	18-37 months
Cardiff and Vale	26 weeks	Longest wait 43 months
Cwm Taf	19-26 weeks	9-36 months
Powys	Up to 20 weeks	30 months

The current waiting times are a result of a discrepancy between need/demand for orthodontic treatment and commissioned orthodontic activity as well as issues with the recruitment and retention of appropriately trained clinicians. Previous Reports have recommended a one off

initiative to clear the treatment backlog, however, this would need to be carefully thought through with regards the overall service provision and there may be greater merits in distributing any additional initiative funding over a longer period to allow a sustainable approach to be adopted, as this would allow for a managed recruitment process to be undertaken with diversification of the workforce as appropriate.

4. Summary & Recommendations

a. There is a wide variation in the waiting times within individual Health Boards and Wales as a whole. This is evident in both primary and secondary care settings. It is suspected that this is primarily due to an intrinsic discrepancy between the treatment need and the commissioned activity, however, the reasons for this need to be fully established and options investigated to address these discrepancies in sustainable way which allows services to adapt.
b. The introduction the Orthodontic MCNs has been greatly beneficial. It is essential that all stakeholders remain fully committed and engaged and that the recommendations of the MCNs are incorporated into HB policy via their Oral Health Strategy Groups and their Oral Health Plans.
c. Continue the collective work of the Strategic Advisory Forum in Orthodontics to obtain a All Wales approach within Orthodontic Provision.
d. Continue with the introduction of the eRMS to produce a universal referral pathway and help identify individuals who require priority assessment and intervention as well as allowing more robust data collection. Although the introduction of the eRMS will streamline the referral process and it is anticipated that there will be an initial reduction in referrals while the referral base adapts to the new system, it is unlikely to have a significant downward effect on treatment need in the long term.
e. The awarding of short term contracts results in a limitation in the flexibility of the Practices to invest and modify their current practices. It is prudent to commission longer term contracts with appropriate quality safeguards incorporated within the KPIs to ensure qualify and productivity. It is essential that any reduction in UOA value is sustainable and that any cost savings achieved due to a reduction in UOA value are reinvested within the orthodontic provision to help address discrepancies between need and capacity.
f. Orthodontics is the most monitored speciality within dentistry. We would advise the continue monitoring of treatment outcomes to ensure quality and value for money is achieved within the framework of Prudent Health Care. The exact monitoring mechanisms will be determined at a HB level under advice from MCN and SAFO.
g. Training, recruitment and retention of the orthodontic workforce within Wales is problematic. This area needs to be investigated and options devised to address it. This needs to be done expediently as upcoming retirements are going to compound the

problem leading to further disruptions to service delivery, and an exacerbation of the excessive waiting times currently experiences within all sectors.

Agenda Item 4

THE WELSH NHS CONFEDERATION
CONFFEDERASIWN GIG CYMRU

	The Welsh NHS Confederation response to the Health, Social Care and Sport Committee's inquiry into dentistry in Wales.
Contact:	[redacted]
Date created:	24th August 2018

Introduction

1. The Welsh NHS Confederation welcomes the opportunity to respond to the Health, Social Care and Sport Committee's inquiry into dentistry in Wales. The Welsh NHS Confederation represents the seven Local Health Boards and three NHS Trusts in Wales. We support our members to improve health and wellbeing by working with them to deliver high standards of care for patients and best value for taxpayers' money. We act as a driving force for positive change through strong representation and our policy, influencing and engagement work.

Overview

2. In 2016-17, £171.6m was invested in dentistry services in NHS Wales.[i] Over five million units of dental activity (UDAs) were carried out, which represents approximately 2.4 million individual NHS dental courses of treatment.[ii]

3. The Welsh Government's *Together for Health: A National Oral Health Plan for Wales 2013-18* set the direction for oral health and dental services improvement in Wales. The plan also sets out the Welsh Government's vision for reducing inequalities in dental health in Wales, particularly among children and young people, which is where the greatest improvements have been made since the Plan was published in March 2013. The 2016 – 17 Annual Report[iii] for the Plan, which provides an overview of the key challenges for dentistry in Wales, highlights that access to timely services and adjusting working arrangements to accommodate the new dental contract is a priority area.

4. In March 2017, the Welsh Government published *Taking Oral Health Improvement and Dental Services Forward in Wales: A Framework outlining priorities for dentistry and a future work programme*. This framework sets out the key priorities for oral health improvement and dentistry in Wales in the short to medium term. It also outlines a future work programme that will inform the update of the Oral Health Plan for Wales.

5. The key themes within *Taking Oral Health Improvement and Dental Services Forward in Wales* are broadly consistent with the terms of reference of this inquiry, which we will respond to below.

Terms of Reference

1. The Welsh Government's dental contract reform

6. The current General Dental Services (GDS) contract, introduced in April 2006, remunerates dentists an annual contract value in return for providing an agreed level of UDAs. General Dental Practitioners (GDPs) say that working towards an activity target is like 'being on a treadmill', and the desire for a new contract has been well-documented.

7. In July 2018, the Welsh Government released a written statement[iv] providing details of the contribution that oral health services will make in achieving whole system change and the vision set out by *A Healthier Wales*,[v] the Welsh Government's Long-Term Plan for Health and Social Care. In this written statement, the Welsh Government reiterated their commitment to achieving this whole system change through contract reform.

8. Contract reform allows Health Boards to adopt a more preventative approach to the planning and delivery of services. This is because the 2006 GDS contract requires the delivery of UDAs as proxy for counting dental treatments, which in practical terms means that there is no incentive for dentists to deliver preventative care, or take on patients with greater needs, because remuneration for providing ten or more fillings is the same as it would be for a single filling. Furthermore, while UDAs are considered the main measurement of dental performance under the 2006 contract, they do not provide assurance of the quality of service being delivered.

9. Phase one of the contract reform programme commenced on 1st September 2017. Health Boards across Wales selected and supported a number of dental practices within their localities to take part in the programme. Having a handful of practices in each Health Board take part in the programme, rather than immediately rolling out the programme to all dental practices, was a positive step because a key concern raised about the 2006 contract was that it had not undergone a pilot study before being rolled-out. The number of practices in each Health Board that participated in phase one of the contract reform programme was broadly proportionate to their population bases – e.g. three in Aneurin Bevan University Health Board (UHB), three in Cwm Taf UHB, four in Abertawe Bro Morgannwg UHB etc. Since phase one commenced, Health Boards have received expressions of interest from significantly more dental practices across their areas to take part in the programme. One of the aims of the contract reform programme is to have at least 10% of dental practices in Wales testing out the new contract by March 2019.

10. Practices participating in the contract reform programme are required to undertake the Assessment of Clinical Oral Risks and Needs (ACORN) toolkit for each patient over a 12-month cycle during their routine appointment. At this appointment, the dental team use the toolkit to lead patient discussion and provide oral health advice/education to the patient and explain any preventative treatment that they may benefit from. Our members welcome this approach as it supports patient engagement, improves patient knowledge of oral health so that they can be partners in their treatment, and encourages a preventative approach to oral health.

11. In accordance with the aims of the programme and the support of their respective Health Boards, dental practices that took part in phase one of the contract reform programme have adjusted their working practices, supporting more effective use of Dental Care Professionals (DCPs), including dental nurses, hygienists and therapists, in the delivery of dental care and treatment to patients.

12. Our members highlight that a further benefit of the contract reform programme has been the reduction, rather than the elimination, of the UDA target by 10%. This has eased both time and financial pressures on dental practices, which in turn has enabled them to complete and submit clinical profiles on all patients assessed and treated under the ACORN toolkit. In June 2018, Public Health Wales NHS Trust produced and shared the initial cut of the practice-based patient and practice profiles drawn from the data collected by the practices. More detailed profile information to support decision-making (factoring in practice size, contract value etc) is anticipated from year-end returns, but early indications show that Health Boards and practices can be confident in the further reduction of UDA targets. Looking ahead, the objective will be to use these more detailed findings to secure more appropriate patient access to dental services and improve oral health outcomes.

13. While Health Boards are generally positive about the reformed contract programme, there are some concerns. Some Health Boards are reluctant to approve more dental practices onto the contract reform programme because reducing contracted UDAs means a reduction in the amount of patient charge revenue (PCR) the Health Board receives. While it is positive that the Welsh Government has committed to provide additional funding should Health Boards achieve the 10% UDA target by March 2019, this funding will only cover the anticipated shortfall in PCR of the practices within each Health Board that are already on the contract reform programme (rather than all dental practices within a given Health Board area). Approving more practices onto the contract reform programme therefore poses a risk to a Health Board's financial position as a significant reduction in PCR will impact service provision at practices on the contract reform programme, as well as the much larger number of practices that are not. Some Health Boards have also reported a fall in patient numbers at those practices that are taking part in the contract reform programme.

14. Some dental practices are reluctant to take part in the contract reform programme as they do not believe that the 10% target to undertake the ACORN toolkit is a reasonable proportion for their contract to be adjusted. This is due, at least in part, to a limited understanding in some dental practices about the contract reform programme and the positive early outcomes that Public Health Wales NHS Trust have reported. It is recognised therefore that further engagement activities are required by the Welsh Government and the NHS to address this. There needs to be a transparent, consistent all-Wales approach to further expansion of the contract reform programme, particularly from March 2019 onwards, and practices should be measured against an agreed set of key performance indicators.

15. It is also noted by our members that the geographical spread of dental practices on the contract reform programme is patchy, with few practices on the programme located in

areas with the highest levels of deprivation. Oral health is closely associated with deprivation.[vi] People living in the most deprived communities in Wales have the worst oral health in Wales so further work needs to be done in these areas to improve access.

16. It is not easy to monitor the changes to working practices facilitated by the contract reform programme within Health Boards' existing dental contract management processes. While this is not considered an issue of urgent concern as those that are part of the programme are fully committed to this approach, a broader roll-out of the contract reform programme would likely require a review of each Health Board's performance monitoring processes and tools to achieve effective implementation.

17. Finally, Health Boards are aware that not all dental practices, particularly those that are single-handed and/or operating in small premises, are able to accommodate additional staff (such as hygienists, therapists and dental nurses) and embrace the multi-disciplinary approach upon which a holistic model of service depends. A key challenge in securing wider take-up of the contract reform programme will be to support and convince smaller practices that they will be in a position to work effectively under the new arrangements.

2. How is 'clawback' money being used by Local Health Boards?

18. The 2006 GDS contract requires Health Boards to pay dental practices 100% of their contract if they have delivered at least 95% of contractual activity as expressed in UDAs. This is the percentage of activity that must be delivered if a practice is to avoid the Health Board 'clawing back' funds. Of the £171.6m invested in dental services in Wales in 2016/17, £6.5m of this was recovered for underperformance (clawback money). This represents 3.8% of the total.[vii]

19. Where a recurring underperformance has occurred below 95%, Health Boards will arrange to meet with the provider to negotiate a more manageable contract target. If this results in a contract reduction, Health Boards will reinvest these funds in other areas of need. This allows Health Boards to offer the withheld funding to other primary care dental practices or hospital-based dental services during the financial year so that funding is not lost to dentistry as a whole. It is also at Health Boards' discretion to pay contractors for over-performance of up to 105% against their contract. The challenging financial environment has meant that this has not happened in recent years. Health Boards have also found that the removal of the potential reward for over-performance was a disincentive for many contractors to achieve more than the 95% required to avoid clawback money and many primary care dental practices have achieved significantly less than this with consequent clawbacks required by the Health Board.

20. Health Boards are using clawback money to invest in primary care dental services and making these services more accessible to vulnerable patient groups. For example, some Health Boards have invested their clawback funds to support improved access to services for people with dementia and people with learning disabilities, as well as a dental conscious sedation service.

21. From a staff perspective, clawback funds are being used to fund Fluoride Varnish courses. The course helps to develop dental professionals through working in a dentist practice environment and attending classroom-based lessons and assessments. Using clawback money, these courses are offered to general dental practices for their nurses to attend free of charge.

22. Health Boards are also using clawback funds to support the preventative agenda by developing initiatives aimed at children and young people. This includes purchasing toothbrushes, toothpaste and child-friendly drinking cups, to encourage children to stop using bottles, for Health Visitors to give to children under three years of age.

23. As highlighted previously, it must be remembered that delivery of the UDA target does not necessarily equate to good access to services and/or quality of dental care. We would emphasise that dental services across Wales should adopt the principles of chronic disease management with an emphasis on person-centred, co-ordinated care that supports the patient to self-manage.

3. Issues with the training, recruitment and retention of dentists in Wales

24. Overall, Health Boards are not facing serious challenges in recruiting and training dental staff when compared to other professionals within the primary care sector. The Wales Deanery has shown that Welsh domiciled students entering Cardiff Dental School generally become dental foundation trainees in Wales, and as a consequence, usually remain in Wales as general dental service performers.

25. However, there are a number of caveats to this. Firstly, recruitment challenges are dependent, to some extent at least, on a Health Board's proximity to Cardiff and the Cardiff University School of Dentistry, with dental practices in the North, particularly in rural areas, reporting the biggest challenges. This is true not only for dentists, but also dental nurses, hygienists and therapists. Indeed, some dental specialities do not exist outside the Dental School in Cardiff. There is a need to develop more intermediary services as part of specialty-led managed clinical networks. This should be linked to opportunities for dentists and Dental Clinical Practitioners to upskill, potentially with a view to managing their own practice in future. At the heart of this must be a sustainable specialist workforce to drive standards, innovation and quality. The newly established Health Education and Improvement Wales is well-placed to support this process.

26. The length of time it takes to become a fully qualified dentist (at least five years at dental school and a subsequent two years at a dental practice) means that student debts are a serious barrier for many people wishing to follow a career in dentistry, particularly for those who wish to work in the NHS (rather than the private sector). Frequent 'altering' of pension benefits has also reduced the number of people entering the system.

27. Costs of training and student debt are accentuated for non-UK citizens. The Welsh NHS Confederation and our members continue to highlight the uncertainty around the rights of EU citizens currently living in Wales and the UK due to Brexit as a barrier to recruitment.[viii] This is true also of EU citizens currently living in mainland Europe who may

be discouraged by the financial implications of moving to the UK to study and/or practice dentistry, as well as the availability of support grants, scholarships and bursaries.

28. Dentistry is following the same trend as other primary care professionals in the sense that newly qualified dentists seem more unwilling to commit to long term or extensive NHS involvement and are less interested in becoming practice owners. Our members report that younger dentists tend to prefer part-time work, particularly for those who trained in urban areas and are therefore more attracted to the lifestyle opportunities offered by town and city environments.

29. In addition to training, there are also retention issues due to increases in practicing costs. This is impacting dentists who would usually retire but would like to continue practicing one or two days per week but are finding that it is no longer cost effective to do so.

30. Finally, our members say that a handful of specialist dental services, particularly paediatric dentistry, special care dentistry and oral surgery, experience the greatest recruitment challenges. We recommend that resources for specialty training posts be targeted on population need, access and impact. Greater involvement from Welsh Government, particularly in relation to public engagement campaigns, may prove to be a useful vehicle for developing specialist training programmes in the future.

4. The provision of orthodontic services

31. The majority of NHS Wales orthodontic treatment is provided to 12-17 year olds, but currently not every Health Board provides the same level of service. For example, while Cwm Taf UHB has an orthodontic service as part of its Community Dental Service, the Health Board does not have specialist practices for orthodontics and so patients needing those services are required to travel to Cardiff and Vale UHB.

32. Assessment of need and the provision of orthodontic services should be considered as part of overall dental services planning and within the context of high prevalence of untreated active tooth decay in Wales' child population. In 2016/17, almost 30% of 12-year olds had at least one permanent tooth that was decayed, missing (extracted due to tooth decay) or filled. Access to effective prevention and remedial dental care for these children should be prioritised.

33. Health Board Primary Care Teams are working to improve orthodontic services by focusing on three key priorities: identifying patterns of inappropriate referrals; planning and delivering appropriate and targeted interventions; and addressing current high waiting times. Waiting times for orthodontic treatment in primary care settings are dependent on the referral acceptance criteria of both primary care-based orthodontic services and consultant-led services delivered through hospital settings.

34. For Health Boards that provide orthodontic services, waiting times for treatment are a key challenge. It has been suggested that this is due, at least in part, to the number of inappropriate referrals to orthodontic services, which can sometimes be considered a 'catch all' when another service may be more appropriate. Health Boards are taking

positive steps to addressing this issue through the Orthodontic Managed Clinical Network (OMCN). Under this network, Health Board Primary Care Teams gather the latest waiting time statistics within their Health Boards and share this will all dental staff with the aim of influencing referral practice. Data suggests that children under the age of 11 are among those most-frequently referred to orthodontics when another service would be more appropriate to address their needs. An electronic referral management system (eRMS) is set to be rolled out across Wales by 2019, which will aim to improve the quality of referrals being made to orthodontic services. Abertawe Bro Morgannwg UHB and Hywel Dda UHB are designated 'early adopters' of the eRMS and both Health Boards anticipate using the system by the end of 2018.

35. We would recommend that the data generated by the eRMS also be used to analyse equity in use of specialist dental services, patient experience, patient outcomes, and identify areas where improvements are needed within each Health Board.

5. The effectiveness of local and national oral health improvement programmes for children and young people

36. Long term trends from the late 1980s to the present day highlight a steady and consistent reduction in both the prevalence and average experience of dental decay among children in Wales. Comprehensive data sets for each Health Board are available via the Welsh Oral Health Information Unit (WOHIU) at Cardiff University.[ix] The unit provides independent professional advice, quality assurance, data cleaning, data verification, data analysis and a reporting service on behalf of the Welsh Government and is commissioned by Public Health Wales NHS Trust.

37. On a national level, Health Boards across Wales are supportive of Designed to Smile,[x] the Welsh Government's national oral health improvement programme to improve the dental health of children in Wales, which was introduced in 2009. According to the WOHIU, levels of dental decay among children in Wales are at their lowest since records began. In the five years leading up to 2016/17, the average percentage of children in Wales with at least one decayed or missing tooth had fallen from 45.1% to 29.6%.[xi] In some Health Boards, the reduction has been even more significant, down from 47% to 28.9% in Abertawe Bro Morgannwg UHB, for example. Some Health Boards have carried out information analysis to see which social groups have seen the greatest improvements in oral health, and early indications show that these are mainly to be found in the most deprived social groups. It is emphasised that the involvement of Designed to Smile in nurseries and schools has been critical to the programme's success and Community Dental Services are well-placed to build on these positive outcomes.

38. The Designed to Smile programme mainly targets schools in the most deprived areas, (e.g. schools within the former Community First areas) but some Health Boards have funded designated Primary Care Teams to attend primary schools that fall outside these areas too by working with Healthy School programme co-ordinators and local authorities. This has proved to be an effective way of engaging young people around oral health, hand out free toothbrushes, drinking cups and toothpaste and support prevention.

39. Health Boards are also working on a local level to improve dental health among children in Wales, for example, through the North Wales Local Oral Health Plan. Betsi Cadwaladr UHB's strategic document for community dental services, *Services for Smiles*, specifically highlights the importance of oral health programmes for children and young people and the Health Board has committed to tackling oral health inequalities in its strategy '*Living Healthier, Staying Well*'.[xii]

40. At Aneurin Bevan UHB, the Primary Care Team has worked with Designed to Smile Team to develop a 'child referral pathway', which aims to improve access to dental services with local dental practitioners for children. Seven dental practices across the Health Board receive direct referrals from the Designed to Smile team, which may be instigated by Health Visiting, Flying Start or Designed to Smile teams. Children are given a unique patient code on referral so that they can be tracked through the system to monitor attendance at appointments.

41. The effectiveness of local approaches to oral health improvement is exemplified by the "Baby teeth DO matter" programme at Cwm Taf UHB. This programme focuses on children living in the Merthyr Tydfil area, where the Health Board say 56.5% of children under the age of five have dental decay. A local project is currently underway in three dental practices in Merthyr Tydfil, where a dentist or dental therapist visits baby clinics to speak to parents of babies and toddlers to emphasise the importance of good dental health, support prevention and increase awareness of the services available locally. The results to date have been extremely positive - in 2017/18, the number of 0-2 year olds who attended a dental appointment at dental practice increased by 39.53% in the Merthyr Tydfil locality. Cwm Taf UHB also report an increase of nearly 17% among children of the same age group across the Health Board as a whole.

42. Despite the success of Designed to Smile and local initiatives however, inequalities in children's oral health persist. Public Health Wales NHS Trust say that 42.2% of five-year olds in the most deprived areas have tooth decay, compared to just 22.3% of five-year olds in the least deprived areas. In 2013/14, 20.2% of three-year olds in the most deprived quintiles already had tooth decay experience. Those from the most deprived areas are further disadvantaged due to their poorer access to dental services as well. To address these inequalities, it is important that professionals work collaboratively and recognise the benefits of a multi-disciplinary approach to oral health improvement.

Other comments

43. In addition to the information highlighted above, the Welsh Ambulance Services NHS Trust (WAST) also plays a key role in supporting and providing advice to people who have dental health concerns or questions through NHS Direct Wales service.

44. NHS Direct Wales, which is part of WAST, is a health advice and information service available 24 hours a day. For patients living in the Abertawe Bro Morgannwg UHB area and Carmarthenshire areas, dental advice is accessed via the 111 service.

45. The call volume NHS Direct Wales receives in relation to dental issues is significant, with over 56,000 calls relating to dental matters between 1st August 2017 – 31st July 2018. This equates to 23% of all calls. This is consistent with previous years, with dental issues regularly featuring in the top three reasons for calling the NHS Direct Wales and 111 services.

46. Through NHS Direct Wales/111, the WAST provide dental helplines for Abertawe Bro Morgannwg UHB, Betsi Cadwaladr UHB, Hywel Dda UHB and Powys Teaching Health Board. The dental helplines include dental clinical assessment, access to Dental Access Clinics or Emergency Dental Services based on access criteria determined by the British Dental Association and respond to general information queries. The online symptom checkers includes those for dental symptoms and dental service information is available for the health information team and the service directory.

Conclusion

47. Health Boards across Wales are positive about the ambitious vision for dental services that the Welsh Government has established in recent years. Feedback from dental practices that are currently piloting the contract reform programme are overwhelmingly positive, and while challenges around access continue, the situation across Wales is steadily improving. This has been made possible thanks to multi-disciplinary working within and between Primary Care Teams and supporting the preventative approach as outlined by the Parliamentary Review of Health and Social Care and *A Healthier Wales.*

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[iii] Welsh Government, 2018. Together for Health: A National Oral Health Plan for Wales Annual Report 2017-18. https://gov.wales/docs/dhss/publications/a-national-oral-health-plan-for-wales-annual-report-2017-18.pdf
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https://gov.wales/about/cabinet/cabinetstatements/2018/59764150/?lang=en
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[xii] Betsi Cadwaladr University Health Board. Our Strategy for the Future,
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Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

	Abertawe Bro Morgannwg University Health Board [ABMU] response to the Health, Social Care and Sport Committee's inquiry into dentistry in Wales
Contact	[redacted]
Date created	30 August 2018

Introduction

1. Abertawe Bro Morgannwg University Health Board [ABMU] welcomes the opportunity to respond to the Health, Social Care and Sport Committee's enquiry into dentistry in Wales. The information and views set out below have already informed inform the Wales-wide report from the Welsh NHS Confederation but are provided in full to reflect a perspective on oral health care services provided and commissioned in the Swansea, Neath Port Talbot and Bridgend county areas. The submission comprises responses on the specific issues the Committee requested in 39, numbered paragraphs across 9 pages.

Welsh Government's Dental Contract Reform

2. In 2017 four of 95 general dental contractors in the ABMU area volunteered and met the locally developed criteria to test out a Wales-revised version of the 2005 General Dental contract which aims to reduce the disincentives to providing holistic, preventive care that are inherent in the original. The problems associated with the 2005 contract are described in other submissions to the Committee. They were so significant that pilots of three alternative models were being piloted across Wales within three years of its inception. By 2011 only ABMU was content to pursue a more effective alternative and continued to support two practices operating without an 'activity' target with very positive results in terms of treatment and access. These two 'Prototype' practices are now providing both a helpful foundation and in-built control test for the dental contract reform programme introduced from September 2017. The six reforming practices (four Contract Reform and the two Prototypes) have, for the past year, formed a ABMU Contract Reform group, supported by the Health Board, Public Health Wales and Chief Dental Officer to share learning, and views on the proposed programme, its benefits, potential pitfalls and how it can be taken forward. ABMU is represented on the Chief Dental Officer's national contract reform group through the Dental Director and Primary Care Manager who has driven and supported much of this work locally.

3. The ABMU pre-2017 legacy is that, from 2011 onwards the two Prototype practices had their standard Unit of Dental Activity [UDA] target removed from their contract and were instead paid on a Capitation and Quality Payment which focused on patient numbers and promoting prevention. Recording of activity on a UDA basis continued as a background check. The practices introduced a new Dental Care Assessment service, increased the focus on prevention, recalled patients based on NICE clinical guidance (rather than fixed 6 month periods) and scored

patients' oral health cards as Red/Amber/Green to give clear indicators of the patients' journey and facilitate a genuinely co-produced plan. Five stages of treatment were identified following assessment and planning: Urgent care, Risk Reduction, Stabilisation, Restoration of Function and Advanced Care. This allowed Practice teams to review the patient's progress with them before committing to providing advanced care, e.g.crowns, implants. The Prototypes also tested a more equitable system for patient charge revenue and allayed fears associated with that aspect of the pilot. By 2017 it had been demonstrated successfully that removing the UDA as a driver from these practices gave clinicians more freedom to make decisions, using their own clinical judgement about what was in the best interests of their patients. Once established, it became evident that more new patients were being seen and the proportion of patients provided with advanced treatment had reduced.

4. The national dental contract reform programme launched in 2017 built upon the Prototypes as well as experience introduced from elsewhere in the UK. They were joined by four other practices in ABMU (14 across Wales) to test a 'blended' contract methodology which comprises a compromise between the GDS contract and the prototype described above. Phase 1 of the contract reform programme (September 2017 – March 2018) reduced, but did not eliminate, the UDA target by 10%, easing the time/financial pressures on practices to enable them to complete and submit clinical profiles on all patients assessed and treated.

5. The six, very different, practices who comprise the Phase 1 Contract Reform group hold a total contract value of approximately £2.2 million to deliver almost 87,000 UDAs or equivalent. The UDA rates per practice varied from £23.13 - £38 (average £26) for contracts ranging from 5,800 to 34,500 UDAs. Between them, they can provide a true test of what might be deliverable with contract restrictions lifted to varying degrees.

6. In June 2018 Public Health Wales colleagues produced and shared the initial draft of the practice-based patient and practice profiles drawn from the data collected by the practices. Further, more detailed profile information that will support decision making, factoring in practice size, contract value etc., is awaited from year-end returns. However that available to date indicates that the Health Board and Practices can be confident in reducing further UDA targets in return for specific quality initiatives to secure greater, more appropriate, patient access to General Dental Services with improved health outcomes.

7. The reform programme has, as an aim, that 10% of Wales' practices will be testing the blended contract by 31 March 2019. The current thinking within ABMU is that the next phase of the reform project, from October 2018, will seek to reduce the contract targets by 10% in at least two more practices* and drop further the UDA target in the phase 1 practices in return for specific quality initiatives, some of which are already being explored. Some examples discussed within the Primary Care team and/or contract reform group to date include initiatives that could:

    - improve practice sustainability and retain Dental Foundation trainees in struggling practices
    - improve patient access to general dental services with demonstrable increases in unique patient numbers (in contrast to current high levels of repeat attenders) and/or
    - support enhanced skills training of General Dentists to help reduce what are currently secondary care waiting times for treatment which could be delivered out of hospital.

    *NB 10% of contractors in Swansea and Neath Port Talbot = 8. There are currently no contract reforming practices in Bridgend county.

8. ABMU is aware that not all practices are in a position to embrace the multi-disciplinary approach upon which a holistic model of service depends. This is particularly the case in those who are single-handed and/or operating in small premises that cannot accommodate additional staff, e.g. hygienists, therapists, dental nurses. As an integral part of its service planning and development in 2018/19 ABMU will undertake a survey, jointly with the Local Dental Committee, of practice staffing and facilities to help gauge the extent to which practices are in a position to remodel the services they provide.

9. It is the view in this Health Board, based on experience to date with the Prototype Practices and the wider contract reform, that the changes have resulted in improved access, especially for the most vulnerable, and the nature of the care provided has been driven more by individual need than a contract target. However, as the programme is rolled out it is important that it is underpinned by robust governance and that changes for individual practices are based on the needs of the local population and not simply an 'all-Wales' framework. Experience from the Prototype practices should be shared nationally and these practices should continue to drive and test innovation. Local management teams will need to ensure they have the resources and the capabilities to support the changes and provide reassurance to Health Boards and Welsh Government.

How 'Claw back' money from Health Boards is being used

10. Since February 2017, investment of all ABMU's funding for primary and community dental services has been guided by a three-year oral health service and financial framework. Now known locally as the Oral Health Delivery plan, its broad plans and progress to invest an increasing amount of the ring-fenced budget up to the full allocation in 2020/1, including contractual recovery monies, referred to above as 'claw backs' - is summarized from 12. below. The reasons why a three-year approach to budget setting and management was both necessary and beneficial lie in the constraints imposed by the General Dental Services [GDS] Contract and local circumstances.

11. The GDS Contract requires Health Boards to pay practices 100% of their contract if they have delivered at least 95% of contractual activity, as expressed in Units of Dental Activity [UDAs]. It is also at Health Boards' discretion to pay contractors for over-performance of up to 105% against their contract. ABMU chose not to recognize over-performance in 2016, primarily because concerns had emerged in the preceding two years about inappropriate contracting practice by a significant number of dental contractors. However the removal of the potential reward for over-performance was a disincentive for many contractors to achieve more than 95%. Many achieved significantly less than this with consequent 'claw backs' required.

12. In 2016/17 ABMU's underspend of the Welsh Government [WG] ring-fenced general dental budget reached almost 7% for a variety of reasons *including* the recovery of monies from contractors who had delivered less than 95% of their contract at year end. A decision made in 2016 to commission all dental activity in ABMU HB via a formal procurement process to improve governance meant that it was not feasible to offer out the recovered funds to contractors willing to undertake additional activity in-year. The formal procurement process replaced an informal arrangement whereby the primary care management team wrote to dentists who met particular criteria (eg location, performance) to gauge interest in undertaking more activity on a non-recurring basis, then awarded it. Delivery of a formal procurement process requires significantly more investment of primary care and procurement management time. Consequently, the whole

of the 2016/17 underspend contributed to supporting the Health Board's overall financial position.

13. Action to prevent a recurrence of this situation was taken from early 2017 to prevent. The offer to pay over-performing contractors who met specific criteria was reinstated, and a three-year investment plan, informed by contract monitoring returns and trends, was developed and agreed within the Health Board in February 2017. This proposed increasing expenditure on dental services in three large steps to ensure the whole dental allocation was invested in oral health care by 2020/1. It was not feasible to achieve this sooner within the existing management resource.

14. The plan was revised in June 2017 when, as a consequence of ABMU's level of underspend, Welsh Government withheld contract uplift monies and increased the patient income target. This had the result of halving the additional monies available to invest in dental services. The revised plan demonstrated how the Health Board would succeed in spending the additional monies that remained and received approval within ABMU (June) and Welsh Government in September 2017. The plan includes a range of service and financial of initiatives to achieve the following broad objectives:

    1. Improve the Oral Health of vulnerable groups, e.g. children, adults in care homes,
    2. Improve equity of access to general dentistry
    3. Reduce variation in dental pathways
    4. Improve access to special care dentistry
    5. Reduce referral to treatment times in restorative dentistry
    6. Improve governance and leadership
    7. Improve compliance with key legislation

15. Through a mixture of schemes, ABMU made significant progress on a range of improvements against objectives that had been prioritized for years 1 and 2:

    - Increased UDA value to £25 for 43 practices who agreed to a range of quality initiatives
    - Commissioned additional activity (30,000 UDAs) in 7 practices in high need areas including new practice in Port Talbot from 2018/19
    - Halved children-only contracts, rewarding practitioners who 'converted' to full range of patients with a higher UDA rate
    - Introduced Referral Management Centre [RMC] and new paediatric pathway to support referrals for treatment under a General Anaesthetic, savings from reduction in latter being reinvested in building alternative pathway
    - Transferred resources to the Community Dental Service recognizing its contribution to providing domiciliary dental services in Bridgend county (only) and to support the new paediatric pathway
    - Enhanced Clinical leadership and management, investing in additional Dental Practitioner sessions, Clinical Leadership roles in Community and Restorative Dentistry and primary care management support.
    - Supported practices to comply with the Equality Act through award of improvement grants to introduce hearing loops, disabled access; commissioned bariatric waiting and toilet facilities in Port Talbot Resource Centre.

16. At 2017/18 year end, it was confirmed that the ring-fenced GDS budget had underspent by less than 2%. The Health Board's overall underspend on dental services (inclusive of General, Community and Restorative Dental services) was also less than 2% and demonstrated an

increase in expenditure towards full investment by 2020/21. ABMU had achieved the twin aim of investing in dental services, whilst also containing plans to ensure they were affordable to the Health Board.

17. In 2018/19, Welsh Government increased the dental allocation to restore the element withheld in 2017/18 on the basis of the demonstrable investment in dental services. However ABMU is not complacent: the advice received in July from Welsh Government colleagues that there needed to be an increase in expenditure in GDS from the level evident at the end of June is taken seriously. The Health Board is confident, and has provided assurance, that the further roll out of its Oral Health Delivery Plan will increase expenditure of the ring-fenced allocation and overall oral health service budget, as a consequence of the full year effect of the initiatives summarized above plus the following:

    - Introduction of an enhanced new dental service for HMP Swansea
    - Further development of new dental service to improve access by asylum seekers
    - Completion and introduction of a new, integrated, pathway and associated service specification for domiciliary care
    - Additional investment and reinvestment in paediatric pathways as consequence of changes made to date and impact of WHC(18)009
    - Remodeling of Restorative Dentistry service, creating intermediate care model with support of additional Dentists with Enhanced Skills

18. Additionally, the plans to invest the dental allocation in 2018/19 (inclusive of contractual recoveries) will include initiatives that did not feature in the original plan but which are considered appropriate to reflect emerging service issues. Notably, concerns about long-term primary care sustainability (referenced at 8. above and 22 below) have resulted in the development of General Dental Practice Fellowship to retain and train young dentists.

19. ABMU will be recovering more monies from contractors for 2017/18 than in the previous year, but this is as a direct result of significant underperformances in a few large contracts, reported by the providers as being the result of vacant dental posts. Proactive contract management, reducing the traditionally underperforming contracts for restricted groups (e.g. children only) if the contractor would not accept all groups of patients also had an impact. It is hoped that increasing intelligence around practice prescribing profiles, local population needs and regular engagement will reduce the need for 'claw back' will reduce in future years. It is also considered that the lines between General, Community and Hospital Dental Services will become less distinct than the historical position. ABMU is actively engaged in integrating the delivery of services and pathways across these areas. This is enhancing scope to deploy specialists to work alongside General Dental Practitioners in primary/community settings, and the development of intermediary services means that dental budgets will need to be considered as a whole rather than ring-fenced to service areas.

Issues with the Training, Recruitment and Retention of dentists in Wales

20. Although some corporate practices have reported that they experience problems recruiting dentists, recruitment is not yet felt to be a major problem in the majority of dental practices in ABMU. However, there is increasing awareness that this is changing in dentistry as in other areas of healthcare. Retention issues amongst the young is now seen as a problem, and the impact of likely retirements amongst senior dentists will need to be quantified and tackled. For example, the 14 training practices have all reported difficulties retaining their Dental Foundation trainees

and, particularly as this problem has been common to all types of practice, including the Prototypes last year, it is felt that this is a consequence of the disincentives associated with the UDA Target-driven GDS contract but also the UK-based allocation of training places. There is also a perception that many young dentists no longer aspire to take on the responsibilities of running a practice. ABMU's Post Graduate Training Unit at Port Talbot has trained 35 postgraduate dentists since completion of its first course in 2010, of which 9 are still working in the ABMU area (two within the Community Dental Service). Work is ongoing to confirm the retention rate for those trained in ABMU's 13 other training practices that would help gauge whether this should be considered a cause for concern, but it is understood that the retention rate generally is significantly less than at the Training Unit and is reducing.

21. ABMU was therefore keen to work with the Deanery to introduce, in September 2015, a 'longitudinal' training programme based around ABMU and Cwm Taf's Dental training units with rotations into practices that provided intermediate care (oral surgery) and the Community Dental Service. The hope was that a two-year training period would provide sufficient time and incentive to encourage trainees to establish roots in the area. However, this proved no more successful than the previous experience and, being as complex to undertake to deliver, the training programme reverted to one year's duration from September 2017.

22. As ABMU has concerns about this issue, it has developed and will pilot a three year General Dental Practitioner Fellowship from September 2018, linked with the Contract Reform programme. Expressions of interest were sought from individual practices and Dental Foundation Trainees themselves to receive funding which would support their placement and training as a Dentist with Enhanced Skills who could contribute to both the practice and the overall requirements of oral health services within ABMU. In 2018 the placement is being offered to train in the provision of Endodontic services (assessment and treatment of root canal disease) through the ABMU Restorative Dentistry-provided MSc course in endodontics and working alongside specialists in an intermediary setting. It is hoped that the chosen individual, as well as some of the annual cohort of six MSc-trained dentists, will be able to strengthen the skill-base of primary care dentistry and ensure that less patients need to be treated in hospital, with consequent reductions in waiting times. If successful, it is hoped that in subsequent years the scheme will attract dentists in other dental sub-specialties, e.g. oral surgery or oral medicine and allow a wider development of Dentists with Enhanced Skills.

23. The introduction of Dental Contract Reform and more use of a varied skill mix in dental practices requires the development of national and local workforce plans to ensure there is sufficient supply of these individuals to support dental practices. As indicated at 8. above, it is also important that practices also have the physical capacity in which they can work – hence the reference to review physical as well as staff capacity in general dental practices, lest it is a barrier to dentists wishing to adopt contract reform.

24. There continue to be difficulties in recruiting and retaining specialists and consultants in the recognized specialities – and some specialities do not exist outside the Dental Hospital in Cardiff. In ABMU it is considered that there is a need to develop more intermediary services as part of specialty-led managed clinical networks. This should be linked to opportunities for dentists and Dental Clinical Practitioners to upskill and eventually provide such care from their own practices. At the heart of this must be a sustainable specialist workforce to drive standards, innovation and quality. Welsh Government is recommended to invest in services that can demonstrate a commitment to provide primary and community based services, including the smaller specialties such as paediatric, restorative and special care dentistry and oral surgery. Resources for specialty training posts should target population need, access and impact rather than

historical criteria. Health Boards should be encouraged to develop specialist training programmes which should help retention of the workforce as well as service provision.

Orthodontic Services

25. ABMU commissions 7 Personal Dental Service Primary Care Orthodontic contracts, three General Dental Service Primary Care Orthodontic contracts (with an orthodontic element attached for a Dentist with Enhanced Skills and provides Secondary Care Orthodontic services from the Morriston Hospital site. Six of the seven orthodontic contractors are based in Swansea, the seventh in Bridgend. The three General Dental contractors (in Neath Port Talbot and Swansea) provide orthodontic services to patients to a treatment plan submitted to and approved by the hospital-based specialists. The remaining contractors and the hospital service provide the whole assessment and treatment pathway.

26. Orthodontic and Specialist contracts are subject to similar contract monitoring processes as standard general or personal dental contracts, although some of reports may differ due to their speciality. Any concerns are raised with the Health Board's Specialist Dental Advisor who grades the level of concern using a 'traffic light' system and appropriate action is then taken. Exception reports are not applicable to specialist Contracts and Orthodontic services and currently Dental Assurance Framework [DAF] reports are not available in Wales. If and when these become available, ABMU will aim to align with guidance in England to include these as part of the monitoring process of orthodontic services.

27. ABMU's primary care management team, with the support of the Orthodontic Managed Clinical Network (ABMU and Hywel Dda) continues to develop policies to improve the quality of orthodontic care to predominately:
    - Identify patterns of inappropriate referrals
    - Plan and deliver suitable targeted interventions
    - Improve waiting times
    - Identify robust waiting times monitoring arrangements.

28. The 7 Primary Care Orthodontic contracts account for approximately 10% of the GDS expenditure budget. They were re-commissioned and awarded in December 2016 and will expire on 30 November 2021. The opportunity was taken to standardise the Unit of Orthodontic Activity rate at £63.15 (now £64.06 pending national uplift). That paid to the DES providers is at a similar level and has yet to be reviewed.

29. The Primary Care Team collates waiting time lists from all orthodontic providers on a quarterly basis and issues this information to all dental practitioners following discussion with the Orthodontic Managed Clinical Network [OMCN] which was re-established in 2017. The information is circulated with the aim of influencing referral practice, particularly to reduce the number of inappropriate referrals, notably of children under 11 years old and those whose orthodontic condition, measured against IOTN1 score, does not meet NHS criteria.

[1] Index of Treatment Need – dental health score indicates a developmental anomaly that would offer health gain from correction

30. Despite the above, waiting times are still unacceptably variable and long with over 3000 patients awaiting consultation across ABMU. The Health Board will continue to work with the support of the OMCN to secure a reduction in inappropriate referrals in line with the recommendations of the Welsh Government's most recent national review by [redacted]. Access to an orthodontist across the Health Board ranges from one month (in one, General Dental practice only) to 36 months from referral to assessment. Waiting time remains at three years in Bridgend compared with 3 to 12 months between the Swansea providers. The team has been actively encouraging Bridgend dentists to send patients to Swansea, and requiring the orthodontists to tighten up on the application of their referral acceptance criteria. It is anticipated that significant improvement will follow the introduction of a new e-referral system across all dental specialties in Wales within the next 18 months; earlier in ABMU and Hywel Dda Health Boards who are designated 'early adoptors' .

31. It is considered that the resources are already in place to support the population needs but work is still necessary to ensure robust acceptance criteria are in place, especially for the under 12 year olds and cross boundary referrals. There is also a need to establish a national Dental Activity Review [DAR] for orthodontics and, as contracts are renewed, it will be essential to emphasise the need for a change in the model of delivering orthodontic specialist service.

The effectiveness of local and national oral health improvement programmes for children and young people

32. A Public Health Wales' dental survey in 2016/17 revealed the lowest levels of dental decay across Wales in young school children since records began, with a consistent decline in the number of children with missing or decayed teeth. Public Health Wales subsequently reported, earlier in 2018, that the proportion of 12 year olds with decayed or missing teeth had reduced significantly over the past five years to 29.6% from 45.1% across Wales. The achievement in the ABMU area was even more significant, reducing from 47% to 28.9% over the same period.

33. The survey of young school children showed that dental disease levels continued to improve across all social groups with most deprived areas seeing the largest reduction in decay. It is considered that the continued increase in the activity of the Designed to Smile team, (an NHS Dental programme funded by the Welsh Government helping children to have healthier teeth) working in schools and nurseries in the Health Board's most deprived areas has made a major contribution to this

34. However it was also confirmed that 16% of three year old children in ABMU were reported as having decayed, missing or filled teeth. With 28,000 of children being cared for by the Health Board's Health Visiting Team, 2016/7 saw the establishment of a Public Health Wales-led "Lift the Lip" campaign with one of ABMU's Health Visiting teams. This has been continued and extended across ABMU. The excellent joint working with the Designed to Smile team to *make every contact count*, now includes closer working with dentists, the Speech and Language Department and school nursing team to prevent dental decay in pre-school and primary school settings.

35. The publication of WHC(17)23 cemented the need for Designed to Smile to focus on the youngest children and ceased the fissure sealant element of the programme. The team continues to provide fluoride varnishing in the 300+ schools and nurseries in which it educates and treats children but was required by the same Welsh Health Circular to cease the education programme for the year 7 age group. The evidence base for the programme change is respected but there is one element of the change in specification with which the local Designed to Smile

team is uncomfortable: removing the oral health presentation to the older age group. Local experience is that doing so has already weakened the bond with the school staff who are now required to deliver the message formerly conveyed by the D2S team and advise that they – D2S – remain in a good position to deliver that message immediately following the application of the fluoride varnish before the children are able to have their lunch.

36. The number of nursery and school settings in which Designed to Smile is delivered continues to rise (exceeds 300) and change, with an additional 18 identified by the Welsh Oral Health Information Unit in 2017. The challenge for the team is securing 100% engagement, e.g. four of the new cohort actively sought their input, three did not engage and five 'actively' refused. Although this position improved subsequently it was not without considerable effort and engagement directly with the schools, through the Healthy Schools teams and others and this will continue to require engagement at senior partnership level to achieve 100% engagement in target areas.

37. Additional work is also ongoing and required within ABMU to strengthen the links from the Health Visiting and Designed to Smile teams to general dental practices to enable them to secure immediate access for children who need dental care. In the past, there was a direct route to the Community Dental Service [CDS]. However, particularly since the publication of WHC(16)9 emphasised the pressing need to ensure the CDS focused on patients with special care dentistry needs rather than healthy children, that route has not been appropriate. Work is therefore ongoing to ensure access to General Dentistry is readily available for these children in deprived areas.

38. In the interim, Designed to Smile is, as required by WHC(17)23, engaging specifically with the 14 Teaching Dental Practices within the ABMU area to ensure Dental Foundation Trainees and senior colleagues are briefed on latest oral health education advice and training and provided, where appropriate, with the means to provide more fluoride varnish treatments within General Dental Practice. The impact of the change in emphasis in the programme will emerge within the next few years.

39. It is considered that Designed to Smile, although still in its infancy is beginning to deliver on its intended outcomes. However, there is also a need to expand oral health education and support to other vulnerable groups such as teenagers and the older population possibly in conjunction with other programmes such as the care homes project which was established with WHC(15)1, *Improving Oral Health in Care Homes*.

Welsh Government's Dental Contract Reform

The current General Dental Services Contract introduced in April 2006 remunerates dentists an annual contract value in return for providing an agreed level of Units of Dental Activity (UDAs). It is well documented that General Dental Practitioners (GDPs) are not happy with the current contract as they feel working towards an activity target is like 'being on a treadmill'. Also some GDPs are reluctant to accept new patients because they don't know the extent of treatment patients may require. UDAs are allocated based on courses of treatment and dental treatment is categorised in the various bandings, so for example a dentist would receive the same number of UDAs whether the patient needed 1 filling or 5 fillings. Also UDAs are the main measurement of dental performance but does not give assurance of the quality of the service.

Cwm Taf University Health Board (UHB) is supportive of Dental Contract Reform and 3 dental practices were approved for the 1st phase in September 2017 and at least 1 additional practice will commence later this year. Therefore 10% of dental practices in the UHB area will be operating under Dental Contract Reform this year.

The UHB is currently reluctant to approve more dental practices as reducing contracted UDAs by 10% also reduces the amount of patient charge revenue (PCR) the UHB receives; the dental allocation is given to Health Boards net of PCR any shortfall in income has an impact on the UHB's financial position. Additional funding has been agreed by Welsh Government should Health Boards approve a minimum of 10% of dental practices. This additional funding only funds the estimated shortfall in PCR for 4 dental practices so it is a risk to the UHB's financial position should it approve more. Any significant reduction in PCR will have impact on other primary care dental services.

One of the criticisms of the current GDS Contract is that it wasn't tested before its introduction in 2006.Therefore the UHB consider it important to pilot Dental Contract Reform on a small number of practices so lessons can be learnt not only in relation to any risk around funding but also the risk assessment process, to which there have already been several changes since Phase 1 was introduced in September 2017. There also needs to be the ICT infrastructures in place to support the new way of working and currently not all dental practices are computerised.

If the % of UDAs is further reduced under new contract a decision is required on how dental contracts are to be monitored to ensure probity and value for money. When the current contract was introduced it took several years before a process was fully agreed and implemented. GDPs need to be fully aware of what is expected from the start in order to avoid any misunderstanding.

The emphasis of Dental Contract Reform is prevention and also use of a different skill mix of staff within the practice. However, feedback from some dentists is they are concerned how this will work in a single surgery or small practice, where they may not have sufficient space to accommodate other practitioners. When the UHB initially sought expressions of interest to participate in Dental Contract Reform, very few practices were interested. Therefore a barrier for extending the number of practices will be convincing dentists that they will be able to work effectively under the new arrangements.

As the number of practices working under the new contract increases, there also needs to be a public awareness campaign. If the new ways of working are not publicised then it is a concern that there is risk of an increase in patient complaints.

How 'clawback money' is used

The General Dental Services Contract states that a Provider is only able to carry forward a maximum of 5% shortfall in UDAs to the following financial year, therefore any breach of contract greater than 5% requires repayment of funding to the UHB.

From the mid-year position in each financial year (i.e. 30th September) the UHB closely monitors activity, comparing actual performance each month to the expected levels of achievement. As the current contract started April 2006 the UHB now has 12 years of trend data to aid the monitoring process.

The UHB communicates with Providers during the financial year when there are concerns that the practice is likely to under achieve against their contract. Occasionally Providers will inform the UHB that they are expecting to fail to achieve 95% of UDAs and will agree for funding to be withheld during the financial year. This allows the UHB to offer the withheld funding to other dental practices or to invest in other dental services during the financial year so funding is not lost to NHS dentistry.

However, the majority of dental providers do not agree to a temporary reduction to their contracts during the financial year, even when the UHB considers that they will almost certainly not meet the contract target. As the UHB has 12 years of trend data, a judgment can be made during the year on the likely financial outcome so a decision can be made whether to invest in other dental services during the financial year.

The UHB currently has GDS contracts with 35 general dental practices for the value of £13m. Every financial year since the introduction of the GDS Contract

some dental providers in Cwm Taf have not met their contract targets; the number and value of repayment has varied each year. The UHB does not look for savings on GDS Contracts but when funding is repaid, it reinvests:

- Offering additional UDAs to other practices when funding is released during the financial year which has resulted in additional UDAs being invested in Merthyr Tydfil and in Cynon Valley
- Purchased equipment in order to commence a Minor Oral Surgery (MOS) service and sedation service for anxious patients in Primary Care.
- Arranging additional Primary Care MOS sessions on weekends to reduce the waiting list.
- Approving improvement grants for a number of dental practices to make them more accessible for disabled patients
- Purchasing hearing loops for every dental practice's reception desk along with Sonido hearing devices for use in surgeries.
- Funding three Fluoride Varnish courses and offered to all general dental practices for their nurses to attend for free
- Purchasing toothbrushes, toothpaste & drinking cup for Health Visitors to give all under 3 year old children
- Resources required for the campaign "Baby Teeth DO Matter"

Recovery of funding for 2017/18 underperformance is estimated to be 2.2% of the total GDS Contracts but the UHB has not yet completed the end of year review process yet so this may not be the actual amount recovered.

Cwm Taf UHB has an approved IMTP therefore the dental budget is no longer ring-fenced. However the UHB is committed to improving the oral health of Cwm Taf patients and does not have an access problem with more than half of dental practices accepting new NHS patients. When funding is repaid due to breach of contract the UHB takes the opportunity to fund new dental initiatives, as described above.

Issues with training, recruitment and retention of dentists in Wales

Recruitment is not currently a problem for the majority of dental practices in Cwm Taf and this is probably due to its proximity to Cardiff and the Dental School. However the corporate practices have reported that they experience problems recruiting dentists and this could be due to Brexit with European graduates less interested in coming to the UK. As with General Medical Practice, it has been suggested that younger dentists seem unwilling to commit to long term or extensive NHS involvement and don't appear to be interested in becoming practice owners; preferring part-time working so as to have work life balance. As the current GDPs retire this may become more of an issue with possibly less experienced dentists unwilling to provide treatment traditionally carried out in primary care.

With the introduction of Dental Contract Reform and more use of a varied skill mix in dental practices there need to be a workforce plan to ensure there is sufficient supply of these individuals to support dental practices.

The provision of orthodontic services

There are no orthodontic specialist practices in the Cwm Taf UHB area and historically patients have always travelled to the specialist practices in Cardiff. When the current contract was introduced in 2006 funding was given to the Health Board based on historic spend in dental practices rather than based on patient population. Cwm Taf UHB therefore has little influence on orthodontic contracts as approx. £750k of funding for Cwm Taf patients sits with Cardiff & Vale (C&V) UHB.

There are concerns over the length of the waiting times for treatment as the UHB has been informed that referral to treatment is approximately 2 years. A recent survey of the waiting lists in C&V practices show that there are over 8,000 new patients with a further 1,700 patients assessed and on review waiting to start treatment. There have been previous reviews of orthodontic services undertaken which have stated that there is sufficient provision in Wales so there will be no further investment into the service.

It has been suggested that these long waiting lists are due to dentists referring patients too early for treatment and an audit of new patient referrals undertaken by the SE Wales LOC in 2015 showed 15% of patients had been referred early. This is an evitable consequence of long waiting lists.

The Managed Clinical Network for Orthodontics introduced a referral form in an attempt to reduce inappropriate/early referrals but this does not seem to have had any impact on reducing the number of referrals to the service. Although the quality of referrals showed positive improvements. It is hoped the electronic referral management system (eRMS) to be introduced across Wales by March 2019 will continue to improve the quality of referrals but ultimately the bottleneck is in treatment capacity.

In Cwm Taf there are orthodontic specialists working for the Community Dental Service but they do not accept referrals from GDPs. Currently CDS is managed by C&V UHB but will transfer to Cwm Taf UHB in April 2019. The service will then be reviewed as to how it can work more closely with the hospital orthodontic service.

Patients tend to be referred to the hospital service even though they do not meet the criteria for complex treatment as parents from the most deprived areas are not able to travel to Cardiff as no transport. This then has an impact on the hospital treatment waiting lists, particularly in Prince Charles Hospital, which is currently 2 ½ to 3 years.

In Cwm Taf there are 3 dentists with enhanced skills (DWES) in orthodontics who work in primary care practices. The 3 DWES work with the hospital consultants and would be able to treat more patients but are limited by their contracted Units of Orthodontic Activity (UOAs). They have a very small number of UOAs based on their earnings during the reference period prior to April 2006.

The effectiveness of local and national oral health improvement programmes for children and young people

Designed to Smile (D2S) started in 2009 and teams visit primary schools to introduce tooth-brushing and fluoride varnish to young children. The D2S Team visit schools in the Community First areas but the UHB also funds a team to visit all the other primary schools not covered by D2S. So every primary school in Cwm Taf has the opportunity to introduce supervised tooth-brushing and fluoride varnish in schools. Unfortunately not every head teacher will agree for this oral health improvement programme to be in their school. The majority of schools participating are fully engaged with the initiative and the programme forms part of their accreditation under Healthy Schools Award.

The most recent survey of 5 year old children shows that across Wales there has been a significant improvement in children's oral health in the last 10 years. However this improvement was not seen in Cwm Taf. What we don't know is would the levels of decay have increased if it wasn't for the current oral health programmes in place? The UHB has made it a priority to improve children's oral health and since September 2017 has now introduced a fluoride varnish programme for those schools not covered by D2S.

Since April 2017 the UHB now funds toothbrushes/toothpaste for Health Visitors to give babies/toddlers twice per year. They also provide the child with a free drinking cup to encourage the child to stop using a bottle.

Is it a factor that children's oral health in Cwm Taf hasn't improved because the number of children accessing dental services has decreased over the years? In 2009, 36,271 children attended a dentist in the previous 2 years however by 2017 that number had reduced to 35,158.

In an attempt to increase the number of children attending a dental practice, the UHB decided to pilot an initiative 'Baby Teeth DO Matter' in the Merthyr Tydfil locality (56.5% of under 5 year old children have dental decay). The UHB has not invested from the UDA contract into this initiative, other than a small amount to pay for advertising and promotion. There are currently 3 dental practices in Merthyr Tydfil involved in the pilot and they are linked with GP practices. A dentist or dental therapist visits the baby clinics to speak to parents of babies/toddlers to encourage attendance at a dentist. The 3 dental practices had their contracted UDAs reduced by 5% but their annual contract value remained the same. The 5% funding was used to pay for the dentist or dental therapist to attend sessions at the GP practices.

The pilot is only currently in Merthyr Tydfil but the awareness campaign has been publicised throughout Cwm Taf.

The pilot started in April 2017 and during 2017/18 the number of children attending a general dental practice has increased:

- Total number of children increased by over 1,500 children (4.48%)
- Total number of 0-2 year old children in UHB (target age group of campaign) increased by 16.9%
- Total number of 0-2 year old children in Merthyr Tydfil (where Baby Teeth DO Matter is piloted) increased by 39.53%.

The most recent survey of 12 year old children shows that in Cwm Taf there has been an 18.5% reduction in the % of children with decayed, missing or filled teeth compared to the 2008/09 survey. So D2S has been effective in reducing the levels of decay in 12 year old children.

The UHB needs to continue with prioritizing children under 3 years of age and this will be aided by the refocus of the D2S programme. There is no one initiative alone that will improve children's oral health but parents need to hear consistent messages from all healthcare professionals.

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Inquiry into Dentistry in Wales

1.0 The Welsh Government's dental contract reform

1.1 Aneurin Bevan University Health Board (ABUHB) is fully engaged with the dental Contract Reform Programme (CRP) and selected three practices to take part in phase 1 of the programme, which commenced on 1st September 2017. A further five expressions of interest from practices have been received to take part in the programme from October 2018, resulting in 10% of the total General Dental Services (GDS) contract population taking part.

1.2 Practices participating in the programme have to undertake the Assessment of Clinical Oral Risks and Needs (ACORN) Toolkit for each patient over a 12 month cycle at their routine appointment. At this appointment the dental team uses the toolkit to lead patient discussion and provide oral health advice/education to the patient and explain any preventative treatment that they will benefit from. The dental team will continue to provide this information to patients but the programme is about raising awareness of oral health issues and how patients can help manage their own oral health needs in between their dental appointments to allow stabilisation of treatments.

1.3 The Health Board (HB) welcomes this approach, as it supports patient engagement and focuses on the education and prevention aspects to oral health as well as providing the necessary treatment.

1.4 There is some reluctance from practices to take part in the programme as they do not feel that 10% to undertake the ACORN Toolkit is a reasonable proportion for their contract to be adjusted. Whilst those participating in the programme have acknowledged the benefits of undertaking the toolkit and the positive approach to providing prevention and education, there is still uncertainty within the wider dental community. Further engagement and understanding of the programme is required. Consideration to a national public/patient awareness campaign of the contact reform programme is also required.

1.5 The HB is keen to expand the programme but needs to ensure that there is a transparent and consistent approach, which is agreed at an all Wales level, when developing the programme and how practices should be measured against key performance indicators.

1.6 Taking part in the programme will allow access rates to increase as over time, patient recall time intervals will extend allowing practices to accept new patients. It is anticipated that child access rates will improve. Between September 2017 – June 2018, there has been a 6% increase in access across the three practices taking part in the programme compared to the previous years activity rates.

1.7 At present there are no practices participating in the areas of most need, Caerphilly and Blaenau Gwent. ABUHB recognises that high incidences of poor oral health is linked to poor access to provision of dental services. Significant investment has been made in these two areas, as well as Torfaen and Newport over a number of years to improve access.

1.8 The programme aims to increase the total number of fluoride varnish applications in children, which will help reduce the number of children who have dental decay – therefore reducing the need for dental care, which in turn may reduce the need for general anaesthesia.

1.9 It is extremely beneficial that practices taking part in the programme can now submit their ACORN data using FP17w forms.

1.10 We are still in the initial stages of this programme however the first cut of data for each of the three practices is proven very useful and supports discussions with the dental teams. It provides a snapshot of the number of patients who have undertaken the ACORN Toolkit and provides a clear overview of the clinical needs of patients for each practice. The individual practice report highlights that there is scope to implement extended recall intervals. It is recognised however, that more data over a longer period of time is required.

1.11 The HB is keen to expand the programme and has established two task and finish groups to discuss and explore the opportunities that the programme can support in relation to increasing 'high street' access, prevention, child access and to explore the possibilities of working collaboratively with Neighbourhood Care Network (NCN) colleagues by developing integrated clinical pathways.

1.12 The HB is in the early stages of discussing the development and/or how the following clinical pathways can be implemented: Cardiac, Diabetes, Stroke, Oncology and Dementia. It is envisaged that a suite of service level agreements will be developed which dental practices can choose to participate in, in conjunction with the themes identified by the NCN.

1.13 It is recognised that practices participating in the programme need approximately six months to embed ACORN Toolkit and a further 12/18 months to capture the majority of patients. The next phase of the programme with these practices needs to be established to ensure that the momentum and engagement continues.

1.14 The programme highlights the importance of utilising a multi-disciplinary skill mix within practice to deliver the programme effectively. There are challenges in relation to delivering this which includes, training programmes, time, capacity, space, funds and regulations.

1.15 Many smaller practices have expressed concerns that the programme delivery is more achievable for larger practices, in terms of working from bigger premises which helps when adapting their working requirements and skill mix. Some practices operate from converted houses or have limited scope to expand and are therefore restricted when considering enhancing their skill mix/multi-disciplinary team. Consideration could be given to an Improvement Grant Scheme.

1.16 Introducing a new way of working has highlighted the disparity between dental practices with regard to their Units of Dental Activity (UDA) rate. Approximately 60% of contracts have a UDA rate which is less than the HB average of £26.00. The majority of these practices are situated in areas of highest patient need. The programme does not directly address this, however the HB is exploring ways how this can be addressed using contract reform as the vehicle.

1.17 There is potential that practices that underperform at year end may be more likely to take part in the programme as the percentage tolerance level is reduced. Whilst the HB works with practices to ensure contracted activity is achieved, where financial clawback is applied, the HB re-invests this within dental services.

2.0 How 'clawback money' from Health Boards is being used

2.1 In accordance with Paragraph 84 of the General/Personal Dental Services (G/PDS) Contract and guidance issued by the Welsh Government (WG) (NHS Dentistry *Revised guidance: primary care dental contracts - Advice on managing end of year issues*) the HB applies the agreed principles to all G/PDS contracts at year end.

2.1.1 Activity below 95% - there will be a financial claw back by the HB. Where a recurring underperformance has occurred below 95%, the HB will arrange to meet with Providers in order to negotiate a more manageable contract target. This may result in a contract reduction, which will be reinvested in areas of need.

2.1.2 Activity 95% to 100% - generally the HB will arrange to carry forward this under-performance against the following years contract ie the contracted UDA/Unit of Orthodontic Activity (UOA) level will increase with no corresponding increase to the financial value of the contract. However, where previous carry forward has been agreed and not met, the HB will arrange to meet with providers in order to make financial recovery or negotiate a manageable contract target.

2.1.3 Activity 100% to 105% - the HB will arrange to carry forward this over-performance to the following years contract ie the contracted activity will reduce with no corresponding decrease to the financial value of the contract.

2.1.4 Activity >105% - there will be no financial or UDA/UOA adjustment to the following years contract.

2.2 The HB monitors contracts and meets with providers regularly, especially where a potential underperformance is identified. The HB works with providers seeking a plan on how the activity can be achieved. The opportunity to

temporarily reduce the UDA target is offered and assurance provided that if the target can be met the contract will be fully reinstated.

2.3 In the event that the provider in unable to meet the UDA target a more manageable target is agreed.

2.4 Where a financial clawback is agreed, the provider is advised that a repayment plan can be agreed where monthly installments are made.

2.5 The HB is committed to improving dental services and aims to invest any clawback monies into primary care dentistry.

Since 2014, the HB has significantly invested in the following areas:

2.6.1 'High Street' Access
2.6.2 Primary Care Minor Oral Surgery
2.6.3 Primary Care Orthodontic Service
2.6.4 Prison Dental Services
2.6.5 Urgent Access
2.6.6 Dental Domiciliary Service.
2.6.7 Procured dental/medical equipment.

3.0 Issues with the training, recruitment and retention of dentists in Wales

3.1 Workforce data is currently collated as part of the annual contract review process. However a more robust process is required to inform succession planning, recruitment campaigns and to inform training needs/placements.

3.2 The Wales Deanery has shown that Welsh Domiciled Students, entering Cardiff Dental School, generally become dental foundation trainees in Wales and as a consequence usually remain in Wales as GDS performers. Further recruitment campaigns are required to help increase interest in dental students to remain Wales.

3.3 ABUHB has nine Dental Foundation Training practices. The HB is supportive of these practices and encourages other suitable practices to take part, not only to develop trainee dentists but to also help increase 'high street' access within the area. There has been a decrease in the number of Dental Foundation Training practices across the HB.

3.4 The Community Dental Service (CDS) experience difficulties in attracting suitable Specialists, particularly for Paediatric, Restorative and Special Care Dentistry. It is recognised that approximately 40% of the current CDS workforce will be retiring in the next 10 years. It has been highlighted that there is reluctance from dental trainees to work in CDS premises due to the restrictions that they impose. This issue has been acknowledged by the HB and will form part of the Estates Strategy.

3.5 The CDS is looking to recruit a Specialist in Paediatric Dentistry in CDS to support GDS and training. It is envisaged that training opportunities can be identified for dental providers and performers to enhance their skills to qualify as a Dentist with an Enhanced Skill (DES).

3.6 The HB will support training for GDS practice nurses on how to apply fluoride varnish. The HB will support the possibility of incentivising practices to undertake the necessary training in order for skills to be enhanced and more preventative treatment to be undertaken on the population.

3.7 There are plans to fully utilise the CDS Dental Therapists to provide Direct Access employed by the Health Board to work with Flying Start and Health Visiting teams to identify children 0-5 years old who are not accessing general dental services. The therapists can undertake dental check-ups, provide preventative treatment and dental care for children under 5 years at the Flying Start hubs utilising the Designed to Smile (D2S) Mobile Dental Unit. In addition, the CDS Dental Therapist will sign post patients to their nearest dental practice to receive ongoing dental care.

3.8 The HB employs an Oral Health Improvement Practitioner (OHIP) to:

3.8.1 Provide oral health training to Domiciliary Dental Service (DDS) users and their carers (in line with guidance issued by British Society for Disability and Oral Health as recommended

3.8.2 Deliver fluoride based prevention to DDS users following the Delivering Better Oral Health Toolkit (DBOH)

3.8.3 Work with DDS users, their carers and the DDS providers to ensure planned care does not turn into unscheduled/unplanned care

3.9 The DDS provider refers patients to the OHIP to continue preventative oral health advice/treatment.

3.10 The HB is exploring the possibility of employing an OHIP to work with vulnerable children and adults – linked with NCNs, Care Navigators, Flying Start Teams and School Nurses to support children gaining access to local dental services, identifying children absent from school with dental problems as a priority. It is hoped that this will increase preventative treatment for children under 5 years.

3.11 As part of the GDS Quality and Patient Safety (QPS) group, the HB facilitates an annual Continued Professional Development programme for dental teams. Topics discussed are collaboratively agreed with members of the GDS QPS and Gwent LDC.

3.12 The HB has established an Integrated Oral Health Group (IOHG) which is chaired by the Associate Director for Integration and Innovation, which consists of HB officials and representation from Public Health Wales, LDC, Community Health Council and Health Education and Improvement Wales (HEIW). The HB has developed a good working relationship with the HEIW.

3.13 The Health Inspectorate Wales (HIW) inspect all dental practices. It would be useful for the training courses relating to these areas be available for dental teams to attend to help support practices when undergoing a HIW inspection.

4.0 The provision of orthodontic services

4.1 The HB commissions nine PDS Primary Care Orthodontic contracts and provides Secondary Care Orthodontic services from two Hospital sites.

4.2 The Primary Care Team (PCT) collate waiting time lists from all orthodontic providers on a quarterly basis and issue this information to all dental practitioners. Access across the HB ranges between 3 to 25 months from referral to assessment and 6 weeks to 24 months from assessment to treatment.

4.3 The HB has non-recurrently invested in to Primary Care Orthodontic Services which has significantly reduced the waiting lists as an additional 200 patients were able to receive treatment over a two year period.

4.4 Secondary Care Orthodontic access across the HB ranges between 14 weeks from referral to assessment and 54 weeks from assessment to treatment.

4.5 Since 2015 the HB monitors the Primary Care Orthodontic contracts against the Key Performance Indicators which is reviewed by the HBs Independent Dental Advisors and ratified by the Orthodontic Managed Clinical Network. This information is shared with all orthodontic providers.The Orthodontic Managed Clinical Network (OMCN) developed a transfer and appeals policy which the HB has adopted.

4.6 Between 2008-16, a review of orthodontics was undertaken and recommendations highlighted for HBs to consider. The nine contracts are due to expire on 31st March 2019. The PCT has reflected on the recommendations made within the report, worked collaboratively with other HBs and the OMCN to develop a service specification. A formal tender process will commence.

4.7 The HBs average UOA is £67. The HB will commission orthodontic services based on £56, in line with Betsi Cadwaladr University Health Board. The full primary care orthodontic budget will be committed and will increase access immediately. It is recognised that increasing routine child access may impact on the referral rate to orthodontics.

5.0 The effectiveness of local and national oral health improvement programmes for children and young people

5.1 It is positive to report that Designed to Smile has reduced decay in 5 year olds by 14% as at the last 5 year old survey. The recent 12 year old survey has shown a steady decrease in decay but the HB has the highest number of untreated decay in comparison to other HB areas; 24%. In addition, the highest number of people accessing urgent dental care is 16-45year olds.

5.2 There is still further work to do in relation to oral health improvement in children as identified in the recent publication of the Dental Epidemiological Survey of 12 Year Olds 2016/17. This will be discussed at the Oral Health Promotion Steering Group (OHPSG) and Integrated Oral Health Group

(IOHG). The CDS is undertaking the Dental Epidemiological Survey of 18-25 Year Olds.

5.3 The PCT and D2S Team have worked collaboratively to develop a ‘child referral pathway’ in order for more children to access dental services with local general dental practitioners. 7 practices within the HB area now receive direct referrals from the D2S Team which may be instigated by Health Visiting, Flying Start and/or D2S Teams. Children are given a unique patient code on referral in order to be tracked through the system in case they ‘did not attend’ appointments. The aim of this pathway is to allow as many children as possible to access mainstream dental services.

5.4 The HB purchased 80 Hall Crown Kits and will be providing training to all practices via the CDS Dental Therapists in 2018/19 where a kit will be provided to a practice.

5.5 The CDS Team is training in ‘Making Every Contact Count’ (MECC). This training needs to be tailored and rolled out to all GDS providers.

5.6 The HB is working collaboratively with the OHPSG and local authority colleagues to support the healthy schools campaign, in order to help raise awareness of oral health issues and prevention.

5.7 The HB continues to promote the DBOH toolkit, at every opportunity with GDPs. GDS practices looking to develop preventive models should be given evidence based Oral Health Improvement Programmes.

5.8 The HB has contributed to the 111 Dental Programme to agree principles for what is deemed an appropriate length of time for a child to access routine, urgent or emergency dental treatment.

5.9 The CDS has raised concerns in relation to the possible introduction of patient charges for CDS vulnerable adults and the negative affect this may have.

Agenda Item 5

WRITTEN EVIDENCE FOR HEALTH, SOCIAL CARE AND SPORT COMMITTEE; NATIONAL ASSEMBLY FOR WALES INQUIRY INTO DENTISTRY 2018

Wales Deanery Dental section is confining written evidence to the specific terms of reference in the inquiry which deals with the- *consideration of issues with the training, recruitment and retention of dentists in Wales.*

1. Background

The Dental Postgraduate Section of the Wales Deanery supports postgraduate education and training for the whole dental workforce (Dentists and Dental Care Professionals) in Wales and is responsible for the recruitment, quality management and satisfactory delivery of postgraduate dental training. The Deanery works closely with colleagues from Cardiff University Dental School and liaises frequently with the Office of the Chief Dental Officer (Welsh Government). The dental section is responsible on an annual basis for approximately 170 trainees.

1.1 Dental Foundation Training (DFT)

Dental Foundation Training is the first phase of continuing postgraduate education after graduation and is recognised as a part of career pathways in all sections of the dental profession. The Dental Postgraduate section currently offers opportunities to complete 1 year of Dental Foundation Training (DFT). This equates to one year of training working in GDS/CDS in an approved training practice, with one day a week allocated to educational study. There are up to 74 Dental Foundation trainees (dentists in their first year after qualification- this year is a mandatory requirement for dentists who intend to work in the General Dental Services providing NHS dentistry).

1.2 Dental Core Training (DCT)

Dental Core Training offers the opportunity to broaden knowledge and experience within the dental profession and is a recognised career pathway following the completion of Dental Foundation Training (DFT). Wales has four Dental Core Training Year 1 (DCT1) Schemes that commence in September of each year. There is a 30-day educational element (study days) covering both hospital and community practice.

The main aims of the scheme are to allow participants to broaden their understanding of the inter-relationship between branches of the profession, enabling a more informed career choice and to further develop their dental expertise and skills, building on previous training received as undergraduates and dental foundation practitioners. In addition, there are further career development posts known as Dental Core Training Year 2/3 posts (DCT2 or DCT3). These posts are normally undertaken following completion of training at DFT and DCT1. Currently there are 74 Dental Core Trainees (30 at level 1, 39 at level 2, and 5 at level 3). It is important to note that all of these posts support service delivery in hospital and/or community dental services

1.3 Speciality Training

Over the past few years Dental Specialty Training has expanded considerably and the Dental Postgraduate Section of the Wales Deanery is proud to support a variety of Deanery approved

training programmes across 7 of the 13 GDC approved Dental specialties with a total of 21 current specialty trainees.

Dentists who wish to train to be a dental specialist must complete at least two years of training post-graduation, covering a broad clinical experience. At least one year should be spent in hospital or community practice, and each post must be occupied for a minimum of three months. The exact length of specialty training will depend on the specialty in question. All specialty trainees must register with the Director of Dental Postgraduate Education in Wales, who is responsible for monitoring the trainee's progress and the quality of training received. On completion of training, the trainee will need to pass relevant examinations (depending on the specialty) provided by one of the Royal Colleges and will become eligible for recommendation, by the Director to the General Dental Council (GDC), for the award of a Certificate of Completion of Specialist Training (CCST) which in turn should lead to their name being entered on the GDC's relevant specialist list.

1.4 Dental Care Professionals (DCPs)

Dental Care Professionals (DCPs) is a collective term that includes the following roles: Clinical Dental Technician (CDT), Dental Technician, Orthodontic Therapist, Dental Hygienist (DH), Dental Therapist (DT), and Dental Nurse (DN). The greater use of 'skill-mix', where DCPs play a more pivotal front-line role in dental service provision in the NHS is a principle that aligns with the Prudent Healthcare agenda in Wales.

'Skill-mix' can be divided into role substitution and role supplementation. The former is where DCPs undertake clinical tasks instead of dentists, whereas the latter is where DCPs augment the activity of a dentist. Both are considered to be important in shifting the future provision from a 'cure' to a 'care' model, particularly in dentistry with an emphasis on prevention. Wales Deanery provides a wide range of postgraduate programmes for DCPs which facilitate this process and develops the workforce, extending the skill sets. In particular, a Foundation Training Scheme for Dental Therapists to work in NHS GDS is provided annually with limited subsidised places. DCPs are essential members of any dental team. The GDC registers and regulates all members of the dental team, dentists and DCPs.

2. Current and future issues affecting delivery and success of the training programmes

Over the last few years the team at the Deanery have become aware of a number of issues that could present challenges to the delivery of dental training programmes. These include:

- Policy issues
- National Recruitment processes
- Recruitment and retention issues

2.1 Policy issues

Workforce Intelligence

In 2012 the Chief Dental Officer (Wales) commissioned a review of the dental workforce in Wales (***Analysis of Dental Workforce: NLIAH 2012***). The aim of the review was to compare the anticipated future supply of dental staff against possible future demand, and make recommendations on planning for a sustainable dental workforce. The report highlighted a number of important issues. One of the key problems that was identified was the ability to track dentists' career patterns was constrained by the available data; sufficient data was available to identify the number of dental graduates produced in Wales since 2007 who were in the Welsh workforce in late 2011/early 2012. The data also showed the number of dentists

who completed DF1 in Wales during 2007-2011 and were in the Welsh workforce in 2011/12. On average during the period 2007-2010, 58% of Welsh-trained dental graduates entered the Welsh workforce after completing DF1. ***Undertaking DF1 training in Wales is a significant factor in the decision to continue working in Wales.*** Of these, 90% undertook DF1 training in Wales and 10% undertook it elsewhere before returning to work in Wales.

Whilst the forecasts reported in the Review provide useful information around the expected future direction of the demand for and supply of dentists it is important to recognise, the forecasts have limitations because they do not capture the complexity that affect the dental marketplace. Therefore, any decisions about the supply of dentists should be informed by both the forecasts and additional information

Briefly, at the time of compiling this paper some data on the destination of new graduates (2018) has been obtained. These data indicated that only 28% (23 out of 75) of Cardiff University graduates have taken a DFT position in Wales this year. Trend data on previous cohorts of graduates are currently being analysed. The introduction of Health Education Improvement Wales (HEIW) in October 2018 will bring a significant boost to the development of workforce intelligence and workforce planning for NHS Wales.

Government policy

Two recently published national strategic policy initiatives will have a bearing on DFT training in the future. ***Advancing Dental Care: Education and Training Review*** published by Health Education England (HEE) recently outlined a number of areas which will affect the dental workforce, particularly with regards to commissioning education and training. If all proposals are realised this could signify an important policy shift in the way that all dentists and DCPs are trained. The outcome of this review will not be known for some time. In addition, the Cabinet Secretary has released a written statement ***"A Healthier Wales: the oral health and dental services response"*** which details the contribution oral health and dental services will make in achieving the vision of a whole system change, focused on health and wellbeing. This policy document will have a major influence on how oral health services are organized and delivered in the future, and the workforce needed to support this.

2.2 National Recruitment processes

DFT

Since National DFT recruitment commenced in 2014/15, there has always been competition for DFT places from both UK, EU and overseas graduates. Over recent years a small minority of UK graduates have been unable to gain a place on the programme. This has put a strain on the system as these graduates need to be accommodated in an approved process of training/equivalence in order to obtain a place on a scheme to be able to work in the NHS General Dental Services.

DCT

A National recruitment process for DCTs has recently been introduced. This process has thrown up some different issues for dental services in Wales. Some providers have found it difficult to recruit suitable candidates for these positions. The reasons for this are multifactorial, however the pay differences between England and Wales and the specific geographical locations of these positions have been mentioned in feedback as problems from previous post holders

Specialty

Speciality training places are strictly limited due to the lack of specific funding and, all of the jobs that have been advertised over the last few years have attracted a large cohort of applicants. However, there are issues with the development of new (and the replacement of current) consultant led specialist services in some specialities (in particular – orthodontics and restorative dentistry). There are very many consultant orthodontist vacancies in all parts of the UK. The major issue appears to be the pay differences between a specialist and a consultant working in the field of orthodontics. A qualified specialist orthodontist (with 3 years training) can earn almost twice the salary of an NHS consultant (with 5 years training).

2.2 Recruitment and retention issues

The Dental Section are convinced that there are number of influences that need to be factored into the discussion that relate to the long-term retention of dentists in Wales. These factors include issues relating to the recruitment and delivery of undergraduate dentist (BDS) and DCP programmes at Cardiff University, pay differentials between England and Wales for training grade salaries (see appendix 1) and, the popularity and opportunity of work placements in primary dental care (in rural and remote areas) for those graduates who have completed their DFT programme.

Some rural areas in Wales (and in other parts of the UK) have found it harder than others to recruit and retain dentists. Training additional dentists does not guarantee that they will choose to apply for posts (or establish practices) in these particular areas. Social, cultural and professional opportunities afforded by life in a city have been shown to be important factors in the decision-making process of dental graduates about where they work. If these difficulties remain, government and health service planners will need to develop new and innovative solutions to meet the oral health needs of the local populations. Solutions developed in other parts of the UK; in particular, Scotland should be investigated. The dental workforce in Wales cannot be considered in isolation from the workforces in other parts of the UK and the wider EEA.

In summary the key issues that the dental section would propose to address these problems can be summarised as:

- **HEIW working with Cardiff University to develop a strategy to increase the numbers of Welsh domiciled applicants and entrants**
    - Collect and analyse further relevant demographic data and link to workforce planning
    - Analyse whether the use of cultural and social determinants could be incorporated into CU entry requirements
    - Develop a closer working relationship between undergraduate and postgraduate training processes (e.g. flexible use of outreach facilities)

- **HEIW must ensure that the recruitment and delivery of DFT programmes is improved**

    - Collect and analyse further relevant demographic data and link to workforce planning
    - Identify and use multi-surgery/trainers' dental practices in geographical areas where it is hard to recruit, and, award flexible long-term trainer contracts
    - Develop better training relationships with corporate providers who hold the majority of NHS contracts in North and West Wales
    - Work and publicise improving the undergraduate/postgraduate transition process

- **HEIW must work with LHBs to provide ongoing work/training experiences in the GDS**

    - Using/top slicing in-year LHB GDS NHS dental contract funds to fund and deliver additional DFT+ places in areas of dental access and disease need, in order to provide patients with some continuity of care and practice
    - Working with WG and LHBs to develop an incentives package to encourage working in less popular areas in Wales
    - Working with WG to develop cogent GDP career pathways
    - Work with Government contract reform programme to develop ongoing work opportunities for dentists/DCPs who have completed foundation training.

[redacted]
Wales Deanery
August 2018

Appendix 1
Dental Training Grade Pay scales in UK 2017/18

Annual Salary - £ Gross	England	Scotland	Wales	NI	Comment
DFT	31,356	30,468	31,044	31,176	Wales - Based upon 2017 figures NI – As per SDR 17-18
DCT 1	36,461	34,674	30,665	36,461	Wales - WG pay circular M&D(W)1_2017 dated 6th April 2017 NI – As per Pay and conditions Circular (M&D) 1/2017
DCT 2	36,461	35,121-37,041-38,960-40,880	32,548	36,461	Scotland – Scale Wales - WG pay circular M&D(W)1_2017 dated 6th April 2017 NI – As per Pay and conditions Circular (M&D) 1/2017
DCT 3	46,208	35,121-37,041-38,960-40,880	34,430	46,208	Scotland – Scale Wales - WG pay circular M&D(W)1_2017 dated 6th April 2017 NI – As per Pay and conditions Circular (M&D) 1/2017

Dentistry in Wales Consultation.

Written evidence

[redacted], Head of School, School of Dentistry, Cardiff University

I am delighted, as Head of the School of Dentistry to contribute to this consultation. I will be focussing my views and thoughts to the areas on which I can comment with knowledge therefore not all areas within this consultation will be commented on.

Background to Education in the School of Dentistry

The School of Dentistry sits within the College of Biomedical and Life Sciences in Cardiff University. It was established in 1964. Students are taught primarily within the University Dental Hospital and the School has a strong relationship with Cardiff and the Vale Health Board to enable undergraduate dental education to take place. Students in Year 1 spend the majority of their time in the School of Biosciences where they are taught the underpinning physiology, anatomy and body systems biology. They spend 1 day each week in the School of Dentistry beginning their professionalism education, skills in communication and work with senior students on teaching clinics learning how to take medical histories and develop experience of working in a clinical environment.

In addition to clinical teaching in the Dental Hospital, our students spend significant time in 2 education outreach centres within the community dental service. Year 4 students will spend clinical time in the dental unit in St Davids, Cardiff and Year 5 students will undertake clinical work in the Mountain Ash unit. Student feedback consistently suggests students not only enjoy these placements, but also gain significant clinical experience during this time. IN addition to these outreach centres, students also undertake residential clinical placements in centres across Wales (e.g. Gwent, Wrexham, Morriston) and outside Wales (e.g Plymouth).

Since 2017, we have begun to teach early year BDS students alongside the 1st year Dental Therapy and Hygiene students (both in clinical skills laboratory and on clinic) to emphasize the connected working across the dental team.

At our last GDC visit the School was rated as ‘satisfactory’ (the highest standard you can be awarded) and the School will be visited again in early 2019 as part of the GDC’s new programme of visits. Our last National Student Survey (NSS) results in August 2018 reported that overall satisfaction with the BDS programme was at 95%, which was the 2nd highest in the College of Biomedical and Life Sciences and one of the highest across the University. All graduating students in 2018 were successful in obtaining a Dental Foundation Training (DFT) place.

Issues with the training, recruitment and retention of dentists in Wales

1. The School of Dentistry has 70 undergraduate places each year for home students along with 4 places for overseas students to study dentistry. This number of places has been maintained since the last cut to our numbers (a cut which was seen across the UK). The School does not struggle to fill these places, and applications are in the region of between 6 and 7 applicants for every place available. Entry requirements are published clearly on the School and University website and is consistent with those from other UK Schools. The School has not entered clearing for the Bachelor of Dental Surgery (BDS) programme. Recruitment of dental students is thus strong and consistent.

2. We currently recruit across the entirety of the UK and work within Cardiff University's need to maintain high entry grades as the University is a high tariff institution. However, our entry grades are commensurate with those across the sector.

3. Students comment that their decision to accept offers at Cardiff is influenced by the early clinical contact they receive in Year 1, the environment and opportunities of and within the University and City of Cardiff (small size, manageable living costs and environment).

4. The School has, for many years, adopted admissions approaches to encourage and increase applications from Wales and Welsh applications. Over the past 5 years the percentage of Welsh domicile applications – to enrolment ratio has improved, despite a static or gentle fall in total dental applications. However, relatively few applications come from students in North and West Wales. The School is currently undergoing its 5-year Periodic Review and this area of recruitment is a key focus. The School, now having a dedicated communications and marketing officer, is working with the University Central Recruitment Team who in 2017-18 introduced a north Wales tour to represent Cardiff University programmes. We will have specific dental content in these tours. All degree programme material is bilingual and we have created promotional videos regarding Dentistry at Cardiff delivered by both English and Welsh speaking students.

5. The School is also in the process of identifying Clinical Academic Lead for Welsh Medium Provision and this individual will work with the central team to identify potential Welsh speaking Student Ambassadors for key careers fairs throughout Wales. As Head of School I am also in discussion with the Welsh Dental Society (Welsh speaking general dental practitioners) to explore the opportunity of their members acting as 'School Ambassadors' to assist the School promoting dental careers and the School's programmes in their local areas.

6. We also recognise that the first year of the undergraduate programme, when students are transitioning to University life, is when Welsh speaking students may benefit most from access to Welsh speaking personal tutor. The School does not have many Welsh speaking academic staff and we are exploring the option to provide such tutors both from within the School and from other Schools.

7. However, as a Russell Group Institution we should look to recruit as widely as possible. We thus need to ensure that the programme they undertake in Cardiff, and the clinical experiences they gain in the Dental Hospital from working with our part-time clinical tutors who are practitioners in South Wales and in Outreach encourages them to want to undertake their foundation training in Wales.

8. Adequate and protected funding is required to ensure undergraduate dental education can be maintained but more importantly can embrace a modern dental curriculum including inter-professional education.

9. Currently funding comes from 2 major streams. Student fees are paid to Cardiff University and this funding, along with other income streams (postgraduate programmes, PhD fees, research grants) form the annual expenditure budget the School of Dentistry receives. This covers University academic, part-time clinical tutor and professional service staff salaries and a non-pay budget to support education and research activity. The second major stream is the Dental Service Increment for Teaching (SIFT). This is funding from Welsh Government and provided to Cardiff and the Vale Health Board. This supports the dental hospital infrastructure, vital as it is a teaching hospital and 75% of all treatments in the hospital are delivered by our students. This funding is not protected from cost reduction programmes and in my view it needs to be to ensure we can deliver a proactive dental curriculum in a dedicated teaching hospital.

10. At present applications from 5th year students to enter DFT is managed by COPDEND (Committee of Postgraduate Deans and Directors) and is a joint England and Wales process. This is an issue for retention of graduate dentists within Wales as there is no Wales only system and over 65% of Cardiff graduates leave Wales to undertake DFT elsewhere. We need to develop a process or structure to encourage Cardiff students to undertake DFT within Wales. If we can retain a greater number of Cardiff graduates I undertaking DFT in Wales there is a chance to encourage them to stay longer term (hospital posts, further education, associate positions in practice) and thus retain students staying in Wales for DFT and beyond as practitioners. There needs to be some different thinking on if this is what is needed and if it can be developed alongside the Scottish and English systems. I have had initial conversations with the Chief Dental Officer and Postgraduate Dean around this subject.

11. It is important that moving forward we look at the issues as a whole and refrain from looking at the early stages of a dentist in isolation. Why do dentists leave once qualified or after initial practice? Are they returning back home to be nearer family, are there cost issues, is it an infrastructural problem?

The effectiveness of local and national oral health improvement programmes for children and young people.

1. The research from [redacted], especially the Design to Smile programme, has been a significant success. In addition, a key strength in Wales is the work with the Oral Health Information Unit based in the School of Dentistry. Welsh Government currently funds a Senior Lecturer to lead this unit with [redacted]. This unit is vital to WG as it provides data and trends regarding oral heath (including children) in Wales. It is also vital to the School of Dentistry as the undertaken is 'real-time' research providing data which influences policy. The Senior Lecturer supported delivers teaching in Dental Public Health to our students and this places our students in a unique position compared to their peers in other schools as they are able to see how this research delivers for a community. This research also has Research Excellence Framework (REF) opportunities as the outcomes from this work has significant impact. It is vital however that Cardiff University see this as important research and why.

Agenda Item 6

HEALTH, SOCIAL CARE AND SPORT COMMITTEE

INQUIRY INTO DENTISTRY IN WALES

- The Welsh Government's dental contract reform;
- How 'clawback money' from health boards is being used;
- Issues with training, recruitment and retention of dentists in Wales;
- The provision of orthodontic services;
- The effectiveness of local and national oral health improvement programmes for children and young people.

EVIDENCE FROM THE CABINET SECRETARY FOR HEALTH AND SOCIAL SERVICES

1. Purpose

1.1 This paper responds to the five points on which the Committee is seeking views.

2. Dental Contract Reform

2.1 Dental services need to be more responsive, equitable, effective and preventive. They need to be planned and performance managed, with a focus on population need not just on those who currently attend. Individual patient need and outcome can be measured and is being used in service and system redesign within the contract reform programme.

2.2 The principles of prudent healthcare mean supporting patients and the public to gain greater understanding of the dental disease process, and for them to have better self care skills and knowledge. Improving oral health for all and eradicating preventable decay in young children remain the overall goals. We recognise there is still a treatment burden, which impacts on patients and clinical teams that needs to be addressed. System change is necessary, to create the conditions, so that delivering quality, responsive dental care, to those who need it most, can happen, and the contribution of dental practices to 'well-being' and oral health improvement is valued. There is scope to make better use of the skills of the whole team in NHS dental care delivery to increase efficiency and prevention within existing resources

2.3 We have set out five key priorities for 2018-21 and beyond for transforming dentistry:

- timely access to prevention focussed NHS dental care;
- sustained and whole system change underpinned by contract reform;
- teams that are trained, supported and delivering value-based quality care;
- oral health intelligence and evidence driving improvement; and
- improved population health and wellbeing.

2.4 These reflect a shift in policy direction, supporting delivery and reform of the dental contract via whole system change focussed on health and well-being, with a preventive approach to care. At the heart of the change is the need for

new models of care to support a more patient focussed approach and a greater use of skill mix.

2.5 Learning is being used from previous dental pilot experience in Wales. The programme now involves key dental stakeholders in the development, collection and reporting of oral health risks, needs and outcomes of individual patients. Understanding individual and whole practice population need supports dental teams to effectively communicate and deliver personalised care to patients, and work with them to co-produce care plans and improved outcomes. It also supports improved delivery of evidenced-based prevention; implementation of needs-led dental recall intervals; and an increase in the use of skill mix.

2.6 Significant progress is being made to expand and develop the work, with clinicians adopting a risk and needs led preventive approach to care provision. Understanding patient need and risk, and using this information to plan care has been key to these improvements. 'Expectations' for the delivery of evidenced informed preventive interventions and advice have been shared with clinical teams. Communicating clinical findings and oral health risks to patients, and taking time to explain what actions they need to take to improve and maintain their oral health, is being used by dental teams to deliver preventive intervention 'expectations' and better communication with their patients.

2.7 All seven health boards are participating as part of the dental contract reform programme and 22 dental practices (some 5% of the all-Wales total) are collecting and using oral 'need and risk' assessment to plan care, give personalised preventive advice and agree appropriate recall intervals with patients. There is interest from more practices to take part in dental reform programme. It is intended that it will expand at pace and health boards expect to have a minimum of 10% of dental practices in their area taking part from October 2018.

2.8 A preliminary data analysis report for Quarter 4 of 2017-18 for the contract reform practices has provided some encouraging early findings on a number of indicators, particularly detailing the varying needs of practice populations and the proportion of patients with risks and needs. The findings also showed an unexpected increase in access and the application of fluoride varnish (in line with wider transformation), despite the practices only being asked to collect need and risk. While these early findings are positive they should be interpreted with caution as they represent the first returns following the introduction of the new oral health risk and need assessment tool.

3. Clawback money – recovery of funding due to contractual under performance

3.1 Contract payments are made to dental contractors monthly for completion of a required level of activity (measured as Units of Dental Activity "UDAs") assigned to the overall contract value. There can be variation in the value of a Unit of Dental Activity, which does not reflect numbers of patients attending a practice but broadly relates to courses of treatment. Where the contractor performs less than 95% of the activity required under the contract, the health

board is entitled to recover ('clawback'), the amount undelivered. Contractors can also hand back funding if, for example, they have performed within the 5% tolerance level but do not want, or are unable to, provide the level of activity in the following year.

3.2 In terms of the total primary care dental expenditure of £180m in 2017-18, the amount of clawback, at £6.5m, actioned by health boards is relatively small (3.6%). Health boards are contractually required to consider clawback where end of year delivery is below 95% of contacted Units of Dental Activity (UDAs).

3.3 However, while it is right health boards monitor contracts and take appropriate action where contracts are not delivering, we are concerned about overly rigid application and a focus only on % of UDA delivered in isolation to other measures of contract provision. In addition the 'value' of a UDA needs to be adequate to reflect cost of quality care delivery.

3.4 We want to see health boards providing greater year-round support to dental providers who are experiencing difficulty in meeting current activity targets, using contract reform principles, and not simply waiting to recover funding at year end. Particularly in cases where the unit price of the practice UDA is below regional averages, or when a practice has increasing access levels, and/or is delivering care to a high need population. When claw back is applied, without allowance of other factors, it is demoralising and can destabilise some practices. It disproportionally impacts on small practices as they tend to have less flexibility than larger corporate organisations and practices. All practices have fixed costs in the provision of a surgery and staff; claw back does not make allowance for.

3.5 Welsh Government continues to ring-fence the dental budget for those health boards without approved Integrated Medium Term Plans. We know a number of health boards reinvest some of the claw back resources into dental services, but this is not universal.

3.6 We want to see financially secure dental services that deliver greater value and which are supported and funded to deliver expectations safely. Welsh Government are holding health boards to account for the investment we make in dental services and have required improvement plans where we feel health boards need to make further and faster progress. This work is on-going.

3.7 We have set an objective to increase the proportion of contracts governed by measures other than Units of Dental Activity in performance monitoring, such as access, need, quality and outcome measures. We have also asked health boards to look at what more they can do to assist dental practices, established and new contract holders, who might be experiencing difficulty in delivering their contractual commitments.

4. Training, recruitment and retention of dentists

4.1 Despite there being a year-on-year increase in the number of dentists providing NHS care there are some recruitment and retention difficulties, particularly in the more rural areas of North, Mid and West Wales. This includes movement of staff within the larger body corporates from rural to urban areas.

4.2 This is causing difficulty in filling some vacancies and on occasion there are time-lags in commissioning and delivery of services due to recruitment and other issues, such as meeting planning and procurement requirements.

4.3 We are encouraging health boards to use the flexibility within the current contract to address local difficulties. This includes the contract value and associated activity measures, incentivising recruitment in areas where it's been difficult to attract dentists, and looking at making best use of the whole dental team through improved skill mix. They are being encouraged to create more favourable conditions to contract within and thereby attract workforce and stimulate the use of skill mix.

4.4 Health boards already have the ability to target and commission services where there is need. The current contract allows the flexibility to commission services at an appropriate value to reflect local circumstances, including the cost of service provision, potential service availability, level of need/demand etc. We are also starting to explore innovative models to provide care for small populations in rural and remote areas by working with existing practices and health boards to consider 'hub and spoke' arrangements. Some health boards have secured salaried general practice models managed through the community dental services using personal dental service contract models.

4.5 There is a need to ensure Cardiff University Dental School facilitate applications from North/West/Mid Wales as there is evidence that some students do return to their home region after qualification. In addition it needs to have a focus on fluent Welsh speakers and have been asked to consider promoting within the application process and/or expanding a pre-registration year.

5. Provision of orthodontics

5.1 An independent review of orthodontics, undertaken by Professor Richmond, Professor of Orthodontics at Cardiff University School of Dentistry, found the orthodontic resources currently available appear to be sufficient to provide provision to the current one-year cohort – there is broadly enough money in the system – perhaps not always where it is needed most. Past inefficiencies in referrals and contract delivery have led to delays in orthodontic provision.

5.2 NHS Wales spends some £13.4 million annually on orthodontic services. This represents almost 10% of the total primary care dental budget allocation and 40% of the total spend on children's dentistry in primary care dental services.

5.3 Whilst demand for orthodontic services has been rising for many years, we believe NHS orthodontics must be strictly provided in terms of need, and suitability for care, rather than demand. It is important health boards make provision for NHS orthodontics which is focused on health gain, and based on assessment of need, and not correcting the aesthetic cases that do not fall under the current NHS acceptance criteria.

5.4 There are regional variations in how long an individual may have to wait for both primary and secondary/hospital orthodontic treatment. Even within areas where there are practices and hospitals with good access some patients have to wait. There is evidence some are referred to multiple providers and/or too early due to the perceived 'wait'. A 'first come first served' approach is often taken in managing many orthodontic waiting lists and clinical priority is not sufficiently influencing waiting times. We expect action to be taken by health boards on these issues and to build on an improving position to ensure clinical priority and efficiency gains are realised.

5.5 We need to do more to ensure there is equitable access to orthodontic services across Wales, by driving through efficiencies. In some instances waiting list sizes are inflated through early referrals for treatment. For example, in 2015-16 compared with 2014-15, there was a 24.3% reduction in the number of "assess and review" appointments i.e. children not ready to receive treatment being held on a list and being reviewed annually until ready for treatment; thereby taking up specialist resource and adding to the perceived 'waiting time'.

5.6 Health boards are now using Managed Clinical Networks (MCNs) to develop processes to identify patients who have been referred to more than one orthodontist, or referred ahead of need, to free up capacity. Both of these practices have falsely increased the length of waiting lists in different areas of Wales.

5.7 The establishment of MCNs has created more efficient referral management process and driven forward improvements in quality and outcomes. Further efficiencies can and will be achieved, reducing early, multiple and inappropriate referrals. A planned electronic referral management service will support addressing these inefficiencies.

5.8 We are working with Public Health Wales, health boards and Chairs of the 3 MCNs to look at need, outcomes, benchmarking and the tender procedures for orthodontic services. This work includes expansion of Key Performance Indicators, particularly in relation to quality, outcomes and data collection.

5.9 One of our immediate priorities includes a continued focus on referral management and waiting lists, linked to the need for dental connectivity and e-referrals. In a direct response to this we have awarded a contract to establish a national Dental e-Referral Management System to FDS Consultants. The implementation is underway and it is expected that the system will be operational this year in the 2 vanguard health boards; with the rest to follow by March 2019.

5.10 The Dental e-Referral Management System will allow triage to influence the flow of *'timely'* referrals into specialist dental services. It will be used across NHS Wales, primary and secondary dental care. The system will improve the quality of referrals and reduce patient waiting times for treatment, including orthodontics. It is expected that between 45,000 and 50,000 referrals will go through the e-referral system each year. Once operational, Wales will be the first country in the UK to implement a fully electronic system for dental referrals in all dental specialties. Patients will be able to track and follow triage decisions and referral destination.

6. Local and national oral health improvement programmes

6.1 Good oral health is an important part of wellbeing. In children, it contributes to physical, educational and social development. Children have been the most significant beneficiaries of recent dental policies and due to the impact of the Designed to Smile (D2S) programme the oral health of young children in Wales is improving across all social groups. There is no evidence of widening inequalities. This is in contrast with previous positions when improved decay levels were normally associated with widening inequality. Improvement across all quintiles of deprivation is significant.

6.2 Trends from a series of surveys of oral health among 5 and 12 year olds conducted over the last two decades highlight a steady and improving reduction in both the occurrence of, and the average, dental decay experience among children in Wales. These survey results are pleasing evidence that prevention works and population health outcomes can be improved with sustained effort and investment in evidence informed practice in service delivery and community programmes.

6.4 The latest dental survey of 5 year old children in Wales (published July 2017) showed the continued steady progress in improving children's oral health, and the emerging impact on D2S. The results showed a 13.4% reduction in the proportion of 5 year old children with decay between 2007-08 (47.6%) and 2015-16 (34.2%). In absolute terms, the most deprived quintile has seen the largest reduction in decay prevalence (by 15%).

6.5 The latest dental survey of 12 year old children in Wales (published June 2018) showed there has been a 16% reduction in experience of decay in 12 year old children between 2004-05 (45.1%) and 2016-17 (29.6%).

6.6 Welsh Government launched the targeted D2S programme in 2008-09 to improve children's oral health in the most deprived communities and has also been piloting a preventive approach to care in dental practices across Wales. Welsh Government continues to invest in D2S and by the end of July 2017 there were 98,568 children in 1,537 schools and nurseries taking part. This represents 66% of all children aged from pre-school to Year 2. The programme also includes application of fluoride varnish by dental teams who visit the nursery or school.

6.7 The number of children undergoing General Anaesthesia for tooth extraction has also reduced from a figure of 9,036 in 2011 to 6,070 during 2017-18. This represents a significant reduction of 3,235 patients in 7 years - a 32.8% fall.

6.8 Whilst the reduction in dental disease in children is encouraging there is little room for complacency. We have recently refocused D2S to further align with the Welsh Government's national strategy, *Prosperity for All,* and to put an even greater emphasis on a child's first 1,000 days. Dental decay is unpleasant and can be painful to experience, is costly to treat and yet is largely preventable.

6.9 There is evidence that some young people (those in the 14 years old plus groups) who did not experience the benefits of D2S and who are from regions of material deprivation are experiencing impact of dental disease severely. Many are losing permanent teeth and some are even experiencing a clearance, of all their natural teeth which is not uncommon.

6.10 We have to date relied on Adult Dental Health Surveys to understand the impact of oral health in young adults. However it has been too small a sample size to make small area needs assessment possible. To that end we have commissioned an epidemiological survey of 18-25 year olds to understand the particular needs of young people and support any service redesign and population public health action as this is such an important group of the population to be oral health literate and economically active.

Agenda Item 7.1

Coleg Nyrsio Brenhinol Cymru
Royal College of Nursing Wales

Ty Hywel
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Dear Dr Dai Lloyd AM

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Director, RCN Wales

16 August 2018

[redacted]

Dai Lloyd AM
Chair of Health, Social Care & Sport Committee

Brexit Symposium: Implications for Health & Social Care in Wales

As you know, on 10 July 2018, the Royal College of Nursing Wales held a Brexit Symposium with a wide range of stakeholders from across the health and social care sectors in attendance, including other Royal Colleges, trade unions and professional bodies. The event provided an opportunity to have a valuable discussion around some of the key areas of concerns regarding the implications that Brexit has for health and social care in Wales, and we were very grateful for your contributions on the day and for chairing a session.

The event itself was prompted by a resolution which Royal College of Nursing members debated at the annual Congress meeting in May. The resolution, which passed, was to lobby the government of the UK for a referendum on the final Brexit deal. Brexit is becoming an increasingly central issue for our members, and it seemed right therefore that we took this opportunity to discuss the issues in detail. It was agreed at the event that a report would be published which captured the discussion and, importantly, made a number of recommendations for the Welsh and UK Governments to take forward. I am delighted to be sharing this report with you today which I hope will be of interest to you. It is hoped that this report will also help building the case for holding a Plenary debate on this important issue after the summer recess.

Coleg Nyrsio Brenhinol Cymru
Royal College of Nursing Wales

If you would like further information, or to discuss any of the issues raised in the report, then please do not hesitate to contact my office.

Kind regards

Yours sincerely

TINA DONNELLY, CBE, TD, DL, FRCN, CCMI DIRECTOR,
RCN WALES

Brexit Symposium: Implications for Health & Social Care in Wales

Recommendations from the Health & Social Care Professions
10th July 2018

Participating Organisations:

British Medical Association
Royal College of GPs
Royal College of Midwives
Royal College of Nursing
Royal College of Physicians
Royal Pharmaceutical Society
Welsh Local Government Association

Executive Summary

Wales' relationship with the EU has a direct and indirect impact on delivery of health and social care. Both the UK Government and the Welsh Government have a responsibility to ensure that the health and social care needs of the population of Wales are not negatively impacted by the UK's departure from the EU. It is critical that both Government's consider the potential impact of departure on the health and social care sector with the same level of priority and concern as the manufacturing or agricultural sectors.

Until the full implications of Britain leaving the European Union are fully understood, there will be an uncertainty around many issues, including the workforce supply chain, workers' rights terms and conditions, research funding and collaboration and reciprocal healthcare arrangements. However commissioning research, engaging experts in the process of risk assessment and engaging stakeholders in the planning process will mitigate this uncertainty.

Throughout this period of uncertainty it is vital that quality of care is maintained and that nurses and health care workers from the EU who are working across the UK continue to feel valued.

On 10th July 2018 the Royal College of Nursing Wales held a Symposium for fellow Royal Colleges and professional bodies in Wales to discuss the implications that Brexit has for the delivery of health and social care services. The programme and full list of attendees is included as an annex to this report. The intention was to discuss issues of common concern.

The discussion was lively and informed and the opportunity to discuss the issues in detail welcomed by all present. Indeed, there was a consensus that the implications of Brexit in the context of health and care is not yet fully understood, and deserves greater focus and attention at UK and Welsh Government level.

Common Themes of Concern:

- The regulation of medicines (i.e. public protection and issues of supply)
- Access to international collaboration in higher education and research (and the impact of this on patient care and workforce recruitment, retention)
- Access to largescale funding to tackle health inequalities (e.g. infrastructure projects)
- The need to safeguard international recruitment as part of ensuring a sustainable workforce
- The need to safeguard working conditions and employment rights as part of ensuring a sustainable workforce.
- A desire to protect the current constitutional ability of Wales to set health policy and legislation as part of the devolution settlement
- Reciprocal healthcare arrangements
- Threats to public health (cross-border disease control etc.)

8 Recommendations for Government

1. The Welsh Government needs to prepare a strategy for international and EU recruitment. The needs of the health and social care sector in Wales need to be a factor in any future UK immigration framework.

2. Health and Social Care professions in Wales value highly the ability of the Welsh Government to make and implement policy and legislation for Wales to be responsive to the country's needs. Our hope is that the Welsh Government and the UK Government will work together over the repatriation of legal powers from the EU in a manner that robustly protects the devolution settlement for Wales.

3. The Welsh Government must engage as widely as possible with relevant experts and agencies within the health sectors in order to inform future policies or legislative changes.

4. The Welsh and UK Government should work closely to ensure that statutory employee protections continue.

5. The Welsh Government needs to prepare a strategy around continued access and promotion of participation in international and EU research collaboration specifically considering its impact on improving patient care and workforce retention. The UK Government also need to consider this matter at UK level.

6. The Welsh and UK Governments should ensure a regulatory system is in place, without break of continuity, to ensure the continued mutual recognition of professional qualifications

7. The Welsh and UK Government should ensure that clear arrangements are in place protect the healthcare rights of Welsh citizens living in Europe and EU citizens living in Wales. Furthermore these arrangements need to be clearly communicated to the communities concerned and to health and social care service providers.

8. The Welsh and UK Government should ensure that arrangements for the continued surveillance of infectious diseases, sharing of relevant data and cross-border health control are in place. Moreover these arrangements need to be communicated clearly to the relevant health and social care organisations and other public bodes both accountable and responsible for action

5 Key Questions for Government

1. What plans does the UK Government have to update the EU/EEA agreement to ensure that nurses from the EEA looking to revalidate post-Brexit are able to do so?

2. Is the Welsh Government planning new guidance for the NHS on data sharing and access to the relevant international electronic systems in relation to public health protection?

3. Has the Welsh Government completed an assessment of risk to the continued and uninterrupted supply of medicines, medical radioisotopes, vaccines, equipment, devices and other supplies?

4. What are the arrangements for implementing the Falsified Medicines Directive and what will happen after March 2019?

5. What scenario-planning is the Welsh Government doing in case of a ‘no deal’?

Coleg Nyrsio Brenhinol Cymru
Royal College of Nursing Wales

Discussion Summary - Impact on the workforce

The potential for Brexit to have a negative impact on Wales' ability to recruit and retain staff from Europe is a significant concern across health and care professions. Wales must be able to continue to attract high calibre professionals, students and trainees, whether in the NHS, social care or independent sector, in order to be able to maintain a stable workforce that can deliver high quality services. The UK Government's approach to immigration has yet to be made clear, with a White Paper expected in the autumn. Participants in the discussion were clear any new rules should allow for the health and social care sector to be prioritised in terms of recruitment, both from within and outside the EU.

While there have been estimates of the number of healthcare professionals from the EU working in the NHS in Wales (e.g. around 300 nurses) the number working in the independent sector is not known, nor the number of health and social care workers. The Welsh Government has recently commissioned research in this area which was strongly welcomed by the participants[1].

The Wales Migration Service has analysed the Labour Force Survey data. Their figures show that there are around 69,000 EU citizens working in Wales: around 4 per cent of the work-force. The Wales Migratory Service analysis shows that around a third of all migrant workers (EU and non-EU) work in public services. If the pattern is the same for both EU and non-EU migrants, that would mean around 23,000 EU citizens working in Wales' public services.[2] This demonstrates that the social care sector is particularly reliant on migrant workers from the EU.

The RCN estimates that there is a shortfall of about 3000 nurses in Wales, and in England the number of vacancies is approximately 44,000. In the context of Brexit and recruitment from Europe, it is also important to note that figures from the World Health Organisation suggest that by 2030, we will need an additional 9 million nurses and midwives in order to be able to meet demand[3]. Nurse recruitment is therefore a global issue, and Wales and the UK are competing in a global market to attract nurses from Europe and around the world.

Another area of concern was the mutual recognition of professional qualifications across European countries. For example the education and training of registered nurses in the UK must conform to standards set out by the EU. This is contained in a law called the Mutual Recognition of Professional Qualifications (MRPQ) Directive.[4] As well as raising the standards of nursing education, the MRPQ Directive has enabled the UK to recruit nurses and doctors from Europe to help fill our own workforce shortages. If the UK decides to move away from these jointly developed standards, the UK may lose important safeguards, lose access to alert mechanisms, and miss out on

[1] http://record.assembly.wales/Plenary/4994#C103879, Vaughan Gething AM, Section 380
[2] *'Implications of Brexit on public services in Wales'*, Nuria Zolle, Wales Public Services 2025, May 2016
[3] http://www.who.int/mediacentre/factsheets/nursing-midwifery/en/
[4] EU Directive 2005/36/EC Annex V.2 (5.2.1)

crucial exchanges between professional regulators. This may have implications for the UK's ability to recruit and retain nursing staff who are EU/EEA nationals.

Also discussed was the issue of revalidation. Currently all nurses who are on the Nursing and Midwifery Council register have to re-register every three years through a process known as revalidation. Post Brexit if there is no clear EU/EEA agreement in place then potentially those nurses who are currently on the register and looking to revalidate may not be able to do so under the Nursing and Midwifery Order 2001.

- How is the Welsh Government going to recruit and retain the European workforce, both within the NHS and the independent and care sectors?

- What more can be done to ensure Wales remains an attractive and welcoming place to live and work?

- What processes are being put in place to ensure the continued recognition of professional qualifications after Brexit?

- What discussions have Welsh Government had with UK Government regarding an EU/EEA agreement to ensure that nurses from the EEA looking to revalidate post-Brexit are able to do so?

Discussion Summary - Reciprocal healthcare arrangements

The current arrangements on reciprocal healthcare are mutually beneficial for UK citizens and citizens from the EU. As such, it is welcomed that the UK Government is currently proposing to continue with these arrangements post-Brexit for UK citizens living in the EU (and vice versa). However, there remains considerable uncertainty and anxiety regarding the details, particularly around the requirements for UK citizens who currently benefit from 'S1' arrangements, to apply for residency within the EU country they are living and the associated costs of local taxes. The future of the EHIC card is also uncertain and it is not clear whether UK citizens will be required to take out private health insurance to travel to Europe.

- What joint working is the Welsh Government undertaking with the UK Government to protect the healthcare rights of Welsh citizens living in Europe (and EU citizens living in Wales)?

Coleg Nyrsio Brenhinol Cymru
Royal College of Nursing Wales

Discussion Summary - Threats to public health

The EU plays a vital role in maintaining public health across all its member states, and there are sector-wide concerns that Brexit and the withdrawal of EU funding for public health measures will negatively impact the health of our population.

The EU facilitates collaboration on cross-border health threats, such as communicable diseases which can spread easily and anti-microbial resistance through the European Centre for Disease Control (ECDC). The ECDC identifies and assesses risks posed to European citizens' health from infectious diseases. Their work monitors potential outbreaks and recommends early warning response systems to protect our health. It is unclear currently what the ongoing relationship with ECDC will be both in terms of submission and comparison of UK data on infections/antibiotic resistance, and the management of outbreaks in Europe that could impact on the UK.

The lack of a contributory relationship to ECDC activities would exclude the UK from reporting and comparing important surveillance data on communicable diseases and health threats. This could affect the preparedness of the UK's health and social care system if a communicable disease outbreak develops and we need to respond rapidly.

Central to the control of infectious diseases is data protection and data sharing. Without rules underpinning the EU system of data sharing, it is unclear how necessary data will be shared and accessed. It is thought that this could even lead to reintroducing a system of quarantine in order to control the spread of disease. The centre for disease control is based in Stockholm but, under data protection legislation, they would not be able to share their data legally with the UK once is outside of the EU. The UK must retain the ability to contribute to, and compare, surveillance data to ensure health systems can deal with cross-border health threats e.g. infectious diseases and the threat of antimicrobial resistance and have robust protection arrangements.

- What are the arrangements for surveillance of infectious diseases and cross-border health control? How will we receive and respond to international health alerts?

- What risk assessments have the Welsh Government conducted into our continued ability to protect the population against cross-border health threats?

- What is the Welsh Governments assessment in relation to data sharing and access to the relevant IT systems in order to enable public health protection?

Discussion Summary - Regulations on medicines

EU regulations contribute a wide range of areas including: the standards of training for nursing staff; the development and approval of medicines; clinical trials participation and regulation; licensing of medical devices (e.g. contact lenses, x-ray machines, pacemakers and hip replacements); licensing of in-vitro medical devices (e.g. pregnancy tests and blood sugar monitoring systems for diabetes).

There is a possibility that the UK will find it more difficult to access medicines and medical devices if we choose to create new frameworks which are different from EU regulations. This may cause delays in new drugs being made available for patients, with the potential to cause significant harm. For instance, we could see delays of 12 to 24 months for UK patients receiving cancer drugs[5]. Ensuring timely access to medicine is critical for all patients in the UK. To achieve this, the UK Government is likely to require a formal agreement with the EU to continue to support and participate in relevant assessments, with a commitment that the UK will maintain and enhance these standards in the future.

The UK Government should also agree mutual recognition of the CE mark between the UK and the EU. The CE mark indicates compliance with EU health and safety standards and allows for free movement of products.

Similarly, there are serious concerns within the health arena in relation to radioisotopes and their movement (currently governed by Euratom). Radioisotopes are highly valuable in medicine, and are widely used in the diagnosis and treatment of disease. Not surprisingly, there are tight regulations surrounding the transportation and importation of radioactive materials. Radioisotopes also have a very short half-life and rapid decay meaning there cannot be any delays in the products reaching patients if they are to be effective. The departure from the Euratom treaty, which governs EU trade in nuclear materials, will potentially create obstacles to these products being imported. Plans need to be put in place now to ensure that the supply of these resources is not interrupted.

Related to this are the concerns around the Falsified Medicines Directive which is due to be rolled out across EU member states from 9 February 2019. The Directive aims to address the significant problems and threats caused by fake medicines. Under the Directive, all new packs of prescription medicines put on the market from February 2019 will need to be booked onto a European Medicines Verification System (EMVS) and will have to have two safety features: a unique identifier and an anti-tampering device. Health professionals will be required to scan medicines prior to administering them and that would then record them as decommissioned from EMVS. IT systems will have to register with SecureMed which is setting up 13 national hubs, and the equipment to scan medicines will need to be available in all GP practices, pharmacies and hospitals.

[5] Ross Hawkins, *Cancer drugs may be delayed after Brexit, say experts*. Available at: **http://www.bbc.co.uk/news/ health-38922366** February 2010.

There are clearly significant logistical and financial implications for complying with this Directive, and there is a complete lack of clarity over what work is currently underway to prepare for being compliant, or what alternative measures will be put in place after Brexit to ensure the UK is still safeguarded against false medicines.

- What is Welsh Government doing to ensure continuing and uninterrupted medicines, medical radioisotopes, vaccines, equipment, devices and supplies?

- What are the arrangements for implementing the Falsified Medicines Directive and what will happen after March 2019?

Discussion Summary - Working conditions and employment rights

Much of existing UK employment law is derived from the EU and it is vital that the protections that this provides for health and social care staff in Wales are continued, and existing terms and conditions preserved. Participants urged the Welsh Government to work closely with the UK Government on this matter. For instance, the existing legislation covers areas such improvements in the safety and health of workers in the UK, and promotes workers' rights around health and safety. There is also the European Working Time Directive which sets out the number of hours an employee can work without taking a break, and the maximum number of hours that can be worked in a week.

Any weakening in the protections which health and care workers in Wales currently benefit from, could result in staff having to work longer hours or in less favourable conditions. This is turn could risk patient safety by increasing the pressure which the workforce is under and reducing morale. The Welsh Government should conduct a risk assessment into the likely impact of Brexit in these areas and work with the UK Government on making sure that they continue.

- The Welsh Government should assess the impact of Brexit on the areas of employment law and employee protections and work closely with the UK Government to ensure they continue

Higher Education and research

Clinical research is undertaken as a partnership between universities and the NHS often across many EU countries. Participants were concerned that Wales will lose opportunities to engage in and lead this type of research. It is well evidenced that international research collaboration increases research excellence, and mobility increases researcher productivity[6]. Opportunities for collaborative research and academic exchange must therefore continue. For instance, £33m was recently announced for health innovation, funded jointly by European Regional Development Fund and Welsh Government. Access to these kinds of funds that must continue.

Furthermore, the impact of withdrawing EU funding from Higher Education could have a serious impact on Welsh Universities' ability to recruit and retain high calibre staff. This is also true for senior medical, nursing and other staff working in higher education. If Wales and the UK become less attractive in terms of academic and research credentials and opportunities, it is likely that some individuals will look to work elsewhere. Similarly, the uncertainty around Brexit and the significant unknowns which surround a number of areas, could see the Higher Education and research sectors losing a number of high calibre and irreplaceable staff members.

There is a risk of loss of access to the EU's research funding programme (Horizon 2020 and the subsequent 9th EU Research and Development Framework Programme) and student exchange programmes (Erasmus+). The UK is currently not expected to be able to participate in the wider policy exchange mechanisms that European Commission initiates and funds, in particular the Health Programme, an initiative which mandates the EU to protect public health.

However participants also noted that the UK is a global player in the fields of research, education and health – collaborating both within Europe and beyond – and Brexit may give Welsh Government an opportunity to re-focus on Wales' strengths in this regard.

- What assurances can Welsh Government provide those working within the fields of research and Higher Education that Wales will remain a place of excellence and opportunity?

- What scoping of opportunities is Welsh Government carrying out for future collaboration and research projects in the EU and beyond?

[6] Department for Business, Innovation & Skills, International Comparative Performance of the UK Research Base – 2013. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/263729/bis-13-1297-internationalcomparative-performance-of-the-UK-research-base-2013.pdf

Discussion Summary - Impact on health inequalities

Wales has some of the poorest regions in the European Union and has been a major beneficiary of EU funds aimed at tackling poverty and reducing health inequalities. Withdrawal of this funding without adequate replacement risks increasing levels of deprivation and exacerbating health inequalities. It is likely that this will be felt most acutely in Wales' rural communities. The UK Government is looking to replace EU Structural Funds, but it is unclear whether Wales would receive the same proportion of funding as it currently does; indeed the alternative currently being discussed at UK Government level is that Welsh local authorities should compete with English local authorities for funding from a new UK fund. The fund will not be distributed on the basis of need but on who can compete effectively. Participants believed the Welsh Government must work hard to advocate for Wales and do everything in its power to ensure that the money that Wales deserves comes to Wales.

Welsh Government must also be mindful of the wider determinants of health, and work hard to ensure that living standards and public services do not decline post-Brexit, as this will have an inevitable impact on the health and well-being of the population as a whole. To quote Dr Julian Tudor Hart FRCGP FRCP – "*Medical services are not the main determinant of mortality or morbidity; these depend most upon standards of nutrition, housing, working environment, and education, and the presence or absence of war."*

- What work is being undertaken by the Welsh Government on the wider determinants of health to ensure that Brexit does not negatively impact on the health and well-being of the population?

Discussion Summary – Devolution and health policy/legislation

The symposium also discussion the devolution and the potential threat which Brexit poses to powers currently held by the National Assembly for Wales. Participants were unanimous in asserting the final deal on leaving the European Union must respect the devolution settlement and should not undermine it in any way. There were concerns that not all EU laws that currently fall with the Assembly's competency will be transposed into Welsh law, and will rather be held by the UK Government before being redistributed. The current devolution settlement which allows health policy to be shaped for Welsh need and encourages citizen participation should be protected.

- What assurance can Welsh Government give that it is firmly and robustly protecting the devolution settlement for Wales and working with the other devolved nations to do the same?

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Conclusion & Future Actions

The opportunity to discuss the issues relevant to the health and social care sectors was welcomed and valued by attendees to the event, and it was agreed that it had been a fruitful and worthwhile discussion.

A number of actions and next steps were agreed:

A report outlining the discussion, identifying common themes and proposed recommendations would be drafted and once agreed by participants would be submitted to:

- Alun Cairns MP, Secretary of State for Wales
- Professor Mark Drakeford AM, Cabinet Secretary for Finance
- Vaughan Gething AM, Cabinet Secretary for Health & Social Services
- Dr Dai Lloyd AM, Chair of Health, Social Care & Sport Committee
- Angela Burns AM, Welsh Conservatives Health Spokesperson
- Rhun ap Iorwerth AM, Plaid Cymru Health Spokesperson
- Caroline Jones AM, UKIP Wales Health Spokesperson

In addition the RCN and other participating organisations would continue to collaborate and look to create other opportunities to raise the profile of these issues, and enhance political and public awareness.

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Annex A – Copy of Symposium Programme

Brexit Symposium: Health & Social Care Concerns

Tuesday 10 July 2018 Future Inns Hotel, Cardiff Bay

09.45 Registration and refreshments

10.00 **Welcome and overview of RCN concerns**
Tina Donnelly CBE, TD, DL, FRCN
Director, RCN Wales

10.15 **Opening Discussion - General Concerns**
- Dr Stephen Monaghan, Chair – BMA Welsh Council's legislation subcommittee, BMA Cymru Wales
- Julie Richards, Chair - Royal College of Midwives Wales
- Cheryl Way, Member Welsh Pharmacy Board, Royal Pharmaceutical Society Wales

Chair: Dr Dai Lloyd AM,
Chair of the Health, Social Care & Sport Committee

10.45 **The Political Response**
- David Rees AM, Labour, Chair, External Affairs and Additional Legislation Committee, & Chair of Cross Party Group on Nursing & Midwifery
  Chair - Cross Party Group on Nursing & Midwifery
- Rhun ap Iorwerth AM, Plaid Cymru
  Shadow Cabinet Secretary for Health, Well-being and Sport

Chair: Dr Dai Lloyd AM,
Chair of the Health, Social Care & Sport Committee

[Please note the Conservative Party and UKIP both gave apologies for this session]

11.15 *Break for tea and coffee*

11.30 **A Message to the Welsh Government**: **Break out Session**
Opening remarks from Rosie Raison,
Policy & Public Affairs Officer, RCN Wales
In groups attendees will be asked to decide on key questions for Welsh Government. These will be published as a report.

12.00 **Brexit: Higher Education and Research**
- Professor Daniel Kelly FRCN RN PhD,
  Royal College of Nursing Chair of Nursing Research
- Diane Powles RGN,
  Education and Lifelong Learning Advisor RCN Wales

Chair: Nigel Downes,
Associate Director, Professional Practice, RCN Wales

12.30 Break for LUNCH

13.30 **Brexit and Health Inequalities**

- Dr Rebecca Payne,
  Chair - Royal College of General Practitioners Wales
- Lowri Gwilym , Team Manager, Europe and Regeneration,
  Welsh Local Government Association
- Dr James Coulson,
  Fellow - Royal College of Physicians

Chair: Nigel Downes
Associate Director, Professional Practice, RCN Wales

14.00 **A Message to the Welsh Government: Break out Session**
Opening remarks from Lisa Turnbull,
Policy & Public Affairs Advisor, RCN Wales
In groups attendees will be asked to decide on key questions for Welsh Government. These will be published as a report.

14.30 **Overview of Discussion**
Tina Donnelly CBE, TD, DL, FRCN
Director, RCN Wales

14.45 **Closing Remarks and Vote of Thanks**
Billy Nichols, Vice Chair, Royal College of Nursing Wales.

15.00 Close of event

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Annex B – Attendee List

Name	Job Title	Organisation
Dr Stephen Monaghan	Chair, BMA Welsh Council's legislation subcommittee	Public Health Wales. BMA Cymru Wales
Julie Richards	Chair, Royal College of Midwives UK & Wales	Royal College of Midwives
Cheryl Way	Pharmacy Lead, NHS Wales Informatics Service and Member Welsh Pharmacy Board	Royal Pharmaceutical Society Wales
Lowri Gwilym	Team Manager, Europe & Regeneration	Welsh Local Government Association
Dr Rebecca Payne	Chair, RCGP Wales	Royal College of General Practitioners
Dr James Coulson	Clinical senior lecturer at Cardiff University, Fellow of Royal College of Physicians	Royal College of Physicians
Professor Danny Kelly	RCN Fellow, Royal College of Nursing Chair of Nursing Research	School of Nursing & Midwifery, Cardiff University
Diane Powles	Education & Lifelong Learning Adviser	Royal College of Nursing Wales
David Rees AM	Chair of External Affairs Committee & Chair of Cross Party Group on Nursing & Midwifery	Welsh Labour/National Assembly for Wales
Dr Dai Lloyd AM	Chair of Health & Social Care Committee	Plaid Cymru/National Assembly for Wales
Rhun ap Iorwerth AM	Plaid Cymru Health Spokesperson	Plaid Cymru/National Assembly for Wales
Joshua Bell	Research for David Rees AM	National Assembly for Wales
Gillian Knight	Nursing Officer	Welsh Government
Liam Anstey	Public Affairs Officer	BMA Cymru Wales
Ross Gregory	Head of External Relations	Royal Pharmaceutical Society Wales
Catherine Evans O'Brien	Health, Housing & Social Care Lead	Older Peoples Commissioner for Wales
Louis Urruty	Policy & Public Affairs Officer	Royal College of General Practitioners Wales
Oliver John	Policy Officer	Royal College of Psychiatrists
Louise Walby	Primary Care Nursing Nurse of the Year Award 2018 winner, Respiratory Nurse Facilitator	Cwm Taf University Health Board
Billy Nichols	Vice Chair, RCN Welsh Board	Royal College of Nursing Wales
Tina Donnelly CBE, TD, DL, FRCN	Director	Royal College of Nursing Wales

Nigel Downes	Associate Director, Professional Practice	Royal College of Nursing Wales
Dr Sue Thomas	Primary Care & Independent Sector Adviser	Royal College of Nursing Wales
Jean Christensen	Education & Lifelong Learning Adviser	Royal College of Nursing Wales
Lisa Turnbull	Policy & Public Affairs Adviser	Royal College of Nursing Wales
Rosie Raison	Policy & Public Affairs Officer	Royal College of Nursing Wales
Liz Newton	Policy & Public Affairs Assistant	Royal College of Nursing Wales

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Annex C – RCN Wales Policy Briefing

Brexit Briefing: Implications for Health & Social Care in Wales

Wales' relationship with the EU has had a substantial direct and indirect impact on delivery of health and social care within the UK. Both the UK Government and the Welsh Government must ensure that the health and social care needs of the population of Wales are not negatively impacted by the UK's departure from the EU.

Until the full implications of Britain leaving the European Union are fully understood, there will be an uncertainty around many issues, including the workforce supply chain, workers' rights terms and conditions, research funding and collaboration and reciprocal healthcare arrangements.

Throughout this period of uncertainty it is vital that quality of care is maintained and that nurses and health care workers from the EU who are working across the UK continue to feel valued.

The key concerns for the RCN in relation to Brexit and its implications are:

- The sustainability of the nursing workforce
    - The potential impacts on the recruitment and retention of the EU nursing workforce should be assessed now and monitored closely over the next decade.
    - The exact figures for the number of EU nurses and the healthcare workers in Wales is not known to the RCN – although we would estimate around 1000 EU nurses in the NHS in Wales
    - The RCN would welcome clarification on this figure as well an assessment of how many EU workers (both registered nurses and healthcare support workers) there are in the independent health and care sectors.

- Safeguarding employment and social law provision, and preserve existing terms and conditions
    - This includes health and safety regulations, working time, consultation on collective redundancies, and safeguarding employment rights in the event of transfers of undertakings (TUPE)
    - The Welsh Government should conduct a risk assessment into the likely impact of Brexit in these areas

- Reciprocal healthcare arrangements
    - Reciprocal healthcare schemes must be retained or suitably replaced, and the rights of EEA and UK citizens living abroad protected.
    - Nurses working in the NHS need to understand and be trained in any new guidance.

- Public health
  - The UK must retain the ability to contribute to, and compare, surveillance data to ensure health systems can deal with cross-border health threats e.g. infectious diseases and the threat of antimicrobial resistance and have robust protection arrangements.
  - The Welsh Government should conduct a risk assessment into the likely impact of Brexit in these areas

- Research collaboration & funding
  - The impact of withdrawing EU funding from Higher Education could have a serious impact on Welsh Universities ability to recruit and retain high calibre staff. This is also true for nursing higher education.
  - Clinical research is undertaken as a partnership between universities and the NHS often across many EU countries. We are concerned that Wales will lose opportunities to participate and lead this type of research.
  - Opportunities for collaborative research and academic exchange must continue e.g. £33m recently announced for health innovation funded jointly by European Regional Development Fund and Welsh Government – access to these kinds of funds must continue.

- Stability of trade arrangements
  - A new regulatory system for medical devices and drug safety must be put in place.
  - The Welsh Government should conduct a risk assessment into the possibility of disruption to supply of medicines and devices
  - New trade deals must not have a detrimental impact on patient care and health workers' employment conditions (e.g. a new TTIP). RCN members were strongly and vocally opposed to TTIP.

- Potential impact on the devolution settlement
  - While issues such as regulation are best dealt with at a UK level, any EU laws that that currently fall within the Assembly's competency, should be transposed into Welsh law
  - The RCN is a supporter of the current devolution settlement which allows health policy to be shaped for Welsh need and encourages citizen participation.

- Tackling social and health inequalities
  - EU Structural Funds have seen significant amounts of money used to support projects which helped to reduce social and thus health inequality
  - Congress resolutions and Welsh Board discussion shows that our members recognise the causes of ill health and often in social inequalities (e.g. homelessness/housing, education and prosperity).
  - The UK alternative currently being discussed is that Welsh local authorities should compete with English local authorities for funding from a new UK fund that will not be distributed on the basis of need. We would argue that need should be the critical factor and funds for Wales given to Wales.

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Key asks/recommendations:

- Welsh Government should engage widely with relevant experts and agencies within the health sectors in order to inform any future policies or legislative changes.

- Welsh Government conduct the necessary risk assessments relating to the potential impacts of Brexit on health and social care so that steps can be taken to mitigate those risks.

- Following a debate at the RCN's Congress event in Belfast, RCN Wales will be consulting with members about supporting a referendum on the final Brexit deal.

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Annex D –Relevant Recent Publications

Written Statement: Brexit – the risks for the future of health and social care in Wales, Vaughan Gething, Cabinet Secretary for Health and Social Services, 26 June 2018
https://gov.wales/about/cabinet/cabinetstatements/2018/brexithealthandsocialcare/?lang=en

External Affairs and Additional Legislation Committee Reports - Wales' future relationship with Europe – Part one: a view from Wales
http://www.assembly.wales/laid%20documents/cr-ld11491/cr-ld11491-e.pdf

Royal College of Nursing – Brexit: EU nurses in the UK - https://www.rcn.org.uk/professional-development/publications/pdf-006982

Royal College of Nursing – Brexit: Protecting workers' rights after Brexit - https://www.rcn.org.uk/professional-development/publications/pdf-006985

Royal College of Nursing – Brexit: Collaboration for research and learning - https://www.rcn.org.uk/professional-development/publications/pdf-006986

Royal College of Nursing – Brexit: EU regulations on professionals and medicine - https://www.rcn.org.uk/professional-development/publications/pdf-006983

Royal College of Nursing – Brexit: Addressing public health threats - https://www.rcn.org.uk/professional-development/publications/pdf-006984

National Assembly for Wales 'In Brief' Brexit Blog articles and updates - https://seneddresearch.blog/category/brexit/